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MENTAL HEALTH—A LOOK AHEAD *

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OHIO has for years held an outstanding position nationally in the mental-hygiene field. It was among the earliest of the states to develop a well-organized child-guidance clinic, such a clinic being set up both in Cleveland and in Cincinnati. In the latter city there has for years been a carefully designed program of psychiatric education in the medical school; whereas Cleveland has stood out as one of the leaders in the country in the education of psychiatric social workers. Both cities have been outstanding for their progressive community agencies, schools, social agencies, and courts. Many psychiatrists, psychologists, and psychiatric social workers have been trained in these programs.

With all of this, however, the state's public psychiatric program, particularly its Cleveland State Hospital, has been deplorable and it is questionable whether an enduring mental-hygiene program can be maintained by a citizenry that at the same time perpetuates an antiquated public psychiatric service.

As we study one field of public welfare after another, we find a common pattern of development running through them all. Each starts as a community effort to meet an annoying or threatening problem—lack of food, clothing, or shelter; inability to read, write, and figure; encroachment upon the property rights of others; the spreading of communicable

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diseases, endangering life; and suicide, or injury to others. In each case, the response of the community is the same. It is simple in that it fills the bread basket, teaches the three "R's," isolates the sick and the offender, and takes the mentally ill into protective custody.

In each case also these functions fall, sooner or later, into the hands of other than purely perfunctory agents. They become the subject of study by persons of good will, intelligence, and experience, and so, in agency after agency, an attempt is made to discover the factors in our individual or community life that have contributed to these problems. When that stage is reached, all of these agencies find themselves tilling the same soil. It is, for example, a matter of pure accident at times whether a disintegrating family first shows its symptoms in a juvenile court, in school retardation, in a pediatric clinic, or in some other branch of community functioning.

It is interesting also that as these various agencies attempt to till the same soil, their plows become tangled and a stage of quarreling often follows. But I have observed that this stage tends to be temporary, for through contact, painful though such contact may be, the agencies come to know one another better, to appreciate that they are working toward the same end, and that the territory is not a proprietary right of any, but the obligation of all.

There are elements in the psychiatric field that retard its progress and cause it to lag behind other fields in health and welfare. Mental hospitals to-day are still insufficiently preoccupied with the discovery of the factors that have contributed to the casualties with which they have to deal. This lag is in no small degree due to the fact that the casualty in this field is ripped out of his community and tucked away in an institution, which may, on occasion, be hundreds of miles distant. The very fact that this asylum is called a hospital obscures the fact that it is not a hospital, and relieves those who are responsible—that is, the whole body of citizens—of the pressure to turn it from an asylum into a hospital. It is not only that the patient has been taken out of his community, which no longer needs to work out a solution for him. It is also a fact that the institution usually has

little or no knowledge of the resources in the community from which the patient came.

Under these conditions, the institution cannot do its best for the patient because it does not know the conditions that contributed to his breakdown—the factors in his family, his job, his leisure-time activities, his opportunities or lack of them. Nor is the community equipped to help either during his absence in the institution or on his return, because too little is known about the procedures and the findings of the institution in which he was confined.

It is not uncommon for a family-service agency to find the structure of a family with which it is working altered because one member has passed out of its midst and into a mental hospital. All that the agency has learned about this family tends to be wasted because there is no channel between agency and hospital. And then, suddenly, the agency finds that, without its knowledge, without its help, and without warning of the added responsibility, the missing member has been returned to the family.

This in a nutshell is the disease of isolation that harasses public psychiatry to-day. It is a long time since it was first diagnosed, and for twenty-five years, attempt after attempt has been made to break into this isolation at one point after another of apparent vulnerability. But over the past century, the mental institution has become a pretty hard-shelled organism. All of the tasks that have had to be performed, administratively at least, have been allocated, and the personnel have come to know their places and their duties. Any attempt to introduce a new functionary into the system must of necessity disturb at least some of the nicely rounded-out divisions of labor. That sort of thing is administratively uncomfortable, and so, for the most part, where these additions have been made, they have existed as excrescences rather than as integrated elements in the institution. Clinics, social service, affiliations with professional schools, have not been absorbed. This same hard-shelled characteristic will militate against any effort that we make to alter this situation.

The isolation of the institution is, however, not the only contributing factor. It must be recognized that there is an evasive public attitude which makes the citizen say: "I don't want to think about mental hospitals. I would rather pay

people to take the responsibility off my shoulders. If things go wrong, I would rather blame and discharge those to whom I have given this responsibility, and get new people in their places, than take in my own hands the task of improving the situation." This public attitude is in no small degree a result of the fact that there is in each of us a sufficient degree of mental abnormality—irrationality, if you will—to make us rather hesitant to face the irrationality of others. What we can do about this, I shall take up later.

I cannot help drawing a parallel between two of Ohio's mental hospitals. I do not think that, fundamentally, either Longview or Cleveland State Hospital has the advantage over the other, and both of them are far from ideal, but Longview, over a long period of years, has had a continuous interest in research. It has enlisted the advice, interest, and coöperation of its nearby medical school, and so it was possible, in 1940, to list it as one of the few state hospitals in the country that could be considered seriously engaged in research. Such a hospital can attract better staff and, without better appropriations, still can achieve a much higher status than one that preserves its isolation. Not that I would have any one think that Longview has completely outgrown its asylum background.

To-day public psychiatry is expressed almost exclusively as a state-hospital program. But the time has passed when a comprehensive public psychiatric program can be conceived of and carried out apart from the other mental-hygiene needs of the community. If the hospital attempts to exist purely as a state hospital, it is to-day in greater danger of deterioration than ever before. There was a time when the outstanding psychiatrists of the country were superintendents of state hospitals; our professors of psychiatry were drawn from that background. But this is no longer the case. When the war was over, Dr. Forrest Harrison conducted (under the auspices of The National Committee for Mental Hygiene and the American Psychiatric Association) a job-information center for returning psychiatrists. Of the 936 that passed through his hands, 60 expressed a willingness to accept a state-hospital job, and these were not the top 60. The others rejected the state hospital for the reason that it did not offer them an opportunity to practice the full range of their pro-

fession as they had been taught to practice it. They would be isolated—cut off from the beginnings of mental illness, and cut off from the convalescent period. The hospital did not offer the consciously designed training that these men wanted. There were, of course, other contributory elements in this rejection.

Isolation has had a similar influence elsewhere. The field of mental deficiency to-day is suffering in the same way. Rural medical service has declined continuously over the past decades as the quality of medical education and the number of physicians have increased, so that as the ratio of physicians to population grew in urban centers, it declined in rural centers. The only answer that has been found to this is to reconceive the whole system of providing medical service, so that a physician can perform his functions in a way that he respects.

The public psychiatric program of the future must be concerned with the mental health of the whole public, whether the citizen be in his home, at work, in a general hospital, or in a mental hospital. It must be concerned with his treatment in a ward or in a clinic, as a client of a social agency, a public-health-nursing agency, or a court, or as a pupil in school. It must be concerned to point out and to correct the deficiencies in community organization that contribute to mental casualties.

This does not mean merely that public funds should be poured into these activities without integrated planning. It means that the staff psychiatrist who is engaged in providing services to the mentally ill within the hospital must be concerned with that hospital as only a part of his full range of activities. Instead of living his life on a ward in the Cleveland State Hospital, the staff psychiatrist's focus should rather be on a neighborhood of some 25,000 population within Cleveland, and on all of the psychiatric problems that beset this population. This, of course, requires a quality of personnel and a type of psychiatric education that the public has not been accustomed to pay for. But there seems to be no other answer, and anything short of this is self-deception. Good psychiatrists know this to be the case and will be attracted to nothing less.

Social workers have known this for a long time, and have

refused to become involved in this outmoded system. This has further delayed the reaching out of the hospital into the community, but has made it clear that the point at which this vicious circle needs to be broken is within the public psychiatric system as it is now narrowly conceived.

Of course, a proposal of this sort might not work at all, or would need considerable modification to work, in a state like Montana, but we consider, here and now, that Cleveland and Cuyahoga County have real possibilities for the development of a new public psychiatry.

Certainly with the leadership that Cleveland has provided in the past, it is exceptionally well prepared to take leadership in this newer public psychiatry. The path over which the movement in this new direction must be followed is full of pitfalls. The most serious of these, as we plan ahead, is moralization and generalization. Berating the public for its neglect does not provide the public with a solution. When out of a committee study the conclusion comes that psychiatric education must be more stimulating, or that the public must be educated, we are too frequently misled into thinking that a program has been devised. Few would disagree with such a conclusion, but fewer would find in the conclusion a clear course of action. Real progress is achieved only by a thorough analysis of these generalities. When we encounter a generality, we must be very specific, first, as to how the problem exists, chapter and verse; second, we must analyze why a problem exists down to the point where a next step is in sight; and third, we must describe that next step in terms that tell us what we are going to do this afternoon or to-morrow morning.

There are four generalities that to-day give us a complete perspective on the aims of the mental-hygiene field. These are: first, that the mentally ill, along with the population generally, shall have decent living; second, that the mentally ill shall have the benefit of what science has to offer for their treatment; third, that the factors that contribute to mental illness shall be attacked and, as far as possible, eliminated; and fourth, that the mental health of the public generally shall be developed so that they may attain a higher degree of effectiveness, satisfaction, and productivity, instead of being permitted to drift along neither sick or robust.

In order to understand the task that lies before us, we must, then, ask ourselves, with respect to each of these generalities, in what ways we have failed to achieve it. And so, for example, we would ask first, In what ways are the mentally ill not provided with humane care? The analysis shows that in a widespread way they are housed badly, fed badly, lack recreation, are badly employed, are injured bodily and insulted, are not dealt with as sick people, and are not kept in touch with and dealt with as a part of a family group.

These are things that we who are relatively well consider to be precious, and yet in some hospitals every one of these standards of human living is violated. But in constructing a program of action, the analysis must be carried further. For example, in what way specifically are the mentally ill badly housed? The analysis shows that they are kept in back rooms of homes, in jails, or in asylums that are antiquated, overcrowded, vermin infested, malodorous, inflammable, poorly designed, and of poor sanitation.

But we must go still further in devising a program, and in each case ask ourselves why are these inhumanities allowed to persist? In attacking overcrowding, as an example, we find that among other things, the answer lies in the failure of state appropriations. One might stop at this point and put pressure on state legislatures, and such pressure may be for a time productive, but sooner or later pressure wears itself out. We have not asked ourselves the question: Why do state legislatures fail? And we have not realized that a pressure program is not related to the answer. Actually, state legislatures fail to appropriate sufficient funds because they are not confident that the citizens will back them up. This is not because citizens are in general diabolically inclined, but because the concept of citizenship in this country, as of 1948, is immature.

While in a democracy the citizens are the government, most citizens think that the government is something apart from them. This is a remnant of feudalism which we have not outgrown, and the citizen of the United States to-day is somewhere between the subject in a feudalistic state and the citizen who is the government, as conceived in our Constitution. Here we have something of fundamental importance

which must be dealt with if we are not simply to deceive ourselves.

Have you any doubt about the present immaturity of citizenship? There are several questions that you can ask yourself. First, would you abuse patients, deny them treatment, and refuse to eliminate the conditions that caused them to break down? Have you abused patients? Most citizens to-day will answer, "No," and yet the government, which theoretically is you, is doing these things. Do you believe in a feudal government in which you are relieved of responsibility and in which you can blame the government for its failures without feeling any obligation to do something about it yourself? Do you believe in a government by the people in which it is your responsibility to see that citizens pay attention to the things that your elected or appointed servants are doing, and if they are not doing their duty, proceed to action? Who abuses patients? Who fails in their treatment? If any citizen says, "Not I," then he still adheres, in a degree, to feudalism.

The strengthening of democracy through the improvement of citizenship is not easy. It is a thing that is very much in the air to-day, when we are confronted with ideologies of a different sort. There is a tendency to think of improving citizenship by exhortation and governmental tricks, such as getting out the vote. Exhortation is futile, and governmental tricks are no sounder than achievement by pressure. If we can really make progress in the maturing of citizenship, we shall not only help the mental hospital, but also provide the one solution that will strengthen democracy. The maturing of the citizen is not the result of exhortation or a study of verbalized principles, as attempted in most classes in citizenship. It comes about, rather, by involving citizens in actually performing, even though in a small way, the functions of a citizen. Our task is to involve as large a number of citizens as possible in studying their community, in planning to meet the community deficiencies, and then in actually stepping in to put the plans into effect. It involves serving as volunteers in various community agencies. The contributions citizens make to these agencies as volunteers have been studied and listed and shown to be decidedly important. But these contributions are as nothing compared to the values that

accrue from the maturing of the citizens themselves and from the influence brought to bear upon their neighbors. This gives a bridge from the old to the new.

There are other bridges that our isolated institutions can build over to communities to overcome isolation. Most of these are technically more effective than the volunteer. But none is as effective as the participation afforded to a large number of people by a local mental-hygiene organization.

Again and again, the failure to develop an adequate psychiatric program can be traced back to defective citizenship.

There are many mental-hygiene societies throughout the United States; almost without exception, these societies have failed to rate the participation of their members above their dues and money contributions. And yet, from this analysis, it is inescapable that personal participation is our most valuable asset. It must be kept in mind that progress cannot be achieved merely by passive membership in a mental-hygiene society.

The personal participation of members in a mental-hygiene program has value also in combating another major obstacle—that is, that widespread sensitivity about facing psychiatric problems because each of us has his own deviations. A mass method of desensitizing the public is to bring them into closer touch with mentally ill persons, to remove some of the mystery surrounding the mentally ill, and to tear away the curtain that surrounds this whole phase of public service.

The training ground for man's participation in his culture is the family, and as the family serves this purpose faithfully, the individual enters his culture with a minimum of conflict. For more protected cultures, the family pattern is well fixed and in tune with it. With the multiplicity of cultures that form the background of family life in America, this fixity is less, and the potentialities for participating in an ideal democratic society are enhanced—although the jeopardies are also increased.

These fluid elements in the American family are heightened by our facility of transportation and communication, by forced migration within our boundaries, and by the divorcement of occupation from home. Combined in one marriage, these diverse cultural elements may, on the one hand, be appreciated by the family as enrichment, or depreciated as

outlandishness. Mental health is thus determined positively or negatively.

With these influences in mind, the mental-hygiene needs of the American family are somewhat clarified. The family needs to know in general what is happening to it, and it is our special task to help them to know. Facilities for interchange between families are important, but important also are the interpretative and creative influences of a variety of community agencies that come into close touch with families before any breakdown has occurred. Particularly important are the public-health nurse, the school, and the church. In instances where breakdown has begun, the family needs the various social, welfare, and clinical agencies of the community. But all of these must strengthen their own equipment beyond the present level in order to carry a responsibility for orienting and guiding the family.

At present such services are not generally available to families throughout the country. They are almost completely limited to urban centers. Often their need is not seen; where it is seen, there may be no money to meet the need; and where there is money, personnel cannot be found. The National Mental Health Act promises to further the progress of such facilities, especially clinics and public-health-nursing agencies, but the shortage of personnel will insure a considerable delay. It is important, therefore, that the training program provided for under this Act should focus on points of personnel shortage.

For the fullest mental-hygiene services to the family, there must, then, eventually be a strengthening of the mental-hygiene competence of a variety of professions, represented by the doctor, the court, the social worker, the clergyman, the teacher, and the supervisor in industry.

And so, as we analyze the problem that is before us—*i.e.*, that of getting at the fundamental causes that are in need of attention—as we ask our three questions—What is wrong? Why is it wrong? How can it be corrected?—we are again and again brought to the same answers: immaturity of citizenship; evasive attitude of the public toward mental illness; a defective concept of public psychiatry—namely, as a psychiatry that functions entirely within mental hospitals; deficient knowledge, which leads us to a need for research;

constricting traditions in professional education, not only in psychiatry, but in all fields that deal with people in difficulty.

We are brought face to face with the importance in some sections of the country of general state poverty. We have become aware of the problems involved in mass service, because it is mass service. We become aware of some defective concepts of human needs—such as the concept that recreation is merely wasting time. We are brought to all of these things, which must become the concern of an organized mental-hygiene activity.

With respect to some of these things, our program must begin with the setting up of a small experimental model, so that instead of pleading for measures and procedures that we think are better, we can plead for those that have proved to be better. Some community in the United States must initiate such models. The past record of Cleveland, the quality of its present personnel, and its leadership in the various fields involved lead one to believe that the prospect of a start here is more promising than in almost any other place.

ORGANIZATION FOR WORLD HEALTH *

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THE subject that is the cause of this meeting is one about which you are all concerned—the whole field of mental health and social health. I have always looked for authorities. Now my authority has become the constitution of the World Health Organization. I think it is a good authority for some of the questions of our time. It may be that the world or health forces may grow beyond that constitution—but that will not happen in this generation. The constitution is a long way ahead of international practice. We cannot count on catching up with it all the rest of our lives.

I should like to quote the first clause in that constitution. In unequivocal terms, by agreement of 63 nations, the word "health" is defined: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Sixty-three nations have agreed that is what the word "health" shall mean from now on. In saying so, they have indicated their own attitude about a great many things. They have recognized that the requirements of the human being in order to live with other people are not just those that were required up until now—the necessities have changed. Now even the "sane mind in a sound body" is outmoded. Now we have responsibility for social health, for being able to live in peace and contributing to the welfare of other people. This social responsibility of the individual has never been recognized before on such a wide international basis.

In the constitution of the World Health Organization, there are many responsibilities in regard to a great many aspects of health, but in regard to mental and social health, the responsibilities are particularly heavy and complicated and

* Address before the board of governors and guests of the International Committee for Mental Hygiene, New York City, April 26, 1948.

difficult. In relation to the other aspects of health, the problem is relatively simple. For instance, in dealing with tuberculosis, it is simple to bring together an expert committee, and they can sit down and draft out a program for an attack on tuberculosis that one can be quite confident will command the respect of all the people who know anything about it throughout the world. One can do the same with malaria and with venereal-disease control. But with mental health, that is not true. It would not be possible to bring together five or six people from all over the world and ask them to draft out a program for W. H. O. and U. N. E. S. C. O. with any hope whatever of getting the support of all the people in all the technical fields concerned throughout the world.

Some of us began to have nightmares about this. Out of these concerns and the anxiety engendered, it began to appear that something drastic must be done. Then it appeared that it might be possible to bring a lot of able people together who were concerned and suffering from certain degrees of anxiety about ourselves, our situation, our techniques, our ability to survive at all, and that if enough of them were brought together, perhaps they could draft out something that would be useful.

The idea that the semantic difficulties should be overcome early in the process came from a variety of sources; no one person invented the idea. It was necessary that this should be made a general effort. It has been recognized that health cannot be done to people; increasingly it is recognized that this is not a problem for the technically qualified people in discrete fields, but rather a necessity for the educatin of all people about what they need to do and can do about the health they want.

It was necessary that all people interested and qualified in this field should be given an opportunity of coming together. The semantic difficulties were enormous. Sociologists, anthropologists, psychiatrists, and so on, all speak different languages; they are jealous of them. Words are excellent things to hide behind—an excellent means of saying things that mean one thing to one person and another to another, and an excellent mechanism for obscuring thought.

Some of us had secondary nightmares about the American

Psychological Association, the American Psychiatric Association, the American Orthopsychiatric Association, and about sixteen others from this country alone coming to this London Congress, each expecting to state its own point of view. One can imagine the chaos that would be produced. Clearly the semantic difficulties would have to be got over in the first place, and it was hoped that many of the most troublesome might be straightened out amicably among people working in study at home with other people personally known to them.

I think this is happening. It is great news that over 200 study groups are working in this country alone. As Dr. David Levy has said, even if nothing else happens, it would be worth all the effort if those 200 study groups were to go on working—as they will. I am convinced that they could not be stopped now. They have become interested and excited. This is going on in other countries as well. The bulletin of this organization is exciting reading. It indicates that large numbers of people who never came together before, never learned anything about one another's technical languages and ways of thinking and working, are now coming to know one another and coming to compromise—at least in their definitions, their languages. It is inevitable that they will become more tolerant, more peaceable.

If this congress works, it will be one of the great historic occasions of the world. If it works, its effect will go on into the future. It must work. Large numbers of very earnest, intelligent, informed people are determined to make it work. For far too long, the informed people have left too many things to the uninformed people, have stood aside from the practical problems of living, gaining recognition by reading erudite papers to one another.

What is really pressing is the translation of what we know now into practice. Practice is generations behind knowledge. You can see it in many aspects of the field of health. It is perfectly possible now to eradicate—and eradicate very quickly, within a few years or months—almost all the major diseases in the world. Malaria, smallpox, tuberculosis, venereal disease, diphtheria, many others, could all be got rid of—from the whole world, without any further knowledge or research, if we had mental health and social health

in the people of the world, if enough people in enough places could think in factual terms and had good mental health. Nothing keeps the diseases alive except ignorance and short-sighted self-interest. Long-sightedness would get rid of those things quickly.

This conference in London will be the first great major step in the direction of translation of technical, informed understanding, on the part of the people who are qualified to know about such things, into terms that are usable for the people of the world.

The World Health Organization and U.N.E.S.C.O. and other organizations of the United Nations are working in these fields—working hard. But very largely they use governments. Governments have great limitations. No government can misrepresent its people; it cannot go far beyond its people in human relations. The governments are supported by the people; they can do only what will be approved by their people.

The problem facing the world is not a problem between governments, but of individual people all over the world. It is the problem of individuals reaching out toward maturity, becoming adults. Certain things that we have accepted have become obsolete in a new kind of world, which we must face if we would live at all in a kind of world that did not exist a few years ago—one in which killing has reached its ultimate possibility. This makes new conditions of living in which no one has lived before; a new kind of citizen is necessary if the human race is going to survive. The problem is the production of enough of that new kind of citizen, soon enough, in enough places. It can be done with the knowledge available now, but it needs education.

It has to be done by mothers and fathers, school-teachers and Sunday-school teachers, by educators, and by all people who have to do with the development of children toward adulthood. Certain of our loyalties we do not like to give up; some of them we must recognize are outmoded.

Until recently we could progress from infantile loyalties through those that attached to the immediate community of the family and later to the little group outside the family; it did not matter if millions of people did not get beyond a provincial loyalty to a relatively small group. Now it is

of great concern that loyalty should not stop at anything short of world loyalty. No citizen is fully developed short of the status of world citizen.

This is not to decry national loyalty as a stage or stepping-stone to reach to a higher loyalty. This congress in London is a tremendous step in that direction. Its potential effects are incalculable. If, with the pressure that has been put into this organization, with all the work that has been done, it had only produced a visit of Dr. Frank Fremont-Smith to England and of Dr. John Rees to the United States, it would have been worth it, because those visits alone have produced widely varying ideas of what the world is like, and of appropriate action, and the results will be colossal.

It is true that throughout the world suspicion is very widespread. No one is confident of other people's motives; we have come into very close contact now with strange people of whose development we know little. We do not know how they are thinking or the motives behind their behavior. One finds that even in the United Nations deliberations. One finds in international organizations people considering important problems, presuming to negotiate with other people, who do not even know the principles of the religion of the people they are negotiating with. I have known people presuming to negotiate with members of a variety of nations who did not know the principles of Confucianism, Buddhism, or Jainism. That is a hopeless situation of course. The ability of the human race to continue to live depends on our ability in every country to send people to international councils who will understand one another, who know what they are talking about, and who know enough to make them completely tolerant of the people with whom they are negotiating. It can be done, but it requires much education.

This congress can produce a certain number of positive effects. It is to be hoped that it can say a few things. It is not to be expected that those things will be very important, go very far, or be very numerous. I would not presume to say what those agreements might be or the fields in which they might lie. But there should be some—and do not be disappointed if they do not go very far. There are many more steps to take. Out of the congress should come some delineation of the areas of disagreement and lack of under-

standing, the areas in which people are unable to come together and to see problems from a common point of view. There may come out of this congress the delineations of the fields that need work. If the congress can produce these delineations, then there stretches into the future much work to be done by the W. H. O. and U. N. E. S. C. O. They will be in a position to appoint expert committees to study such areas, which may be defined by this congress. Many other studies—and by far the largest volume—will be carried on by the same study groups, and many others that should be organized all over the world.

Now I should like to say a word about the amazing spirit that has permeated the organization from its beginning. Almost nothing else could have commanded such a self-sacrificing attitude as has been constantly found throughout this organization. On this side and in England, each is so afraid of doing something the other will not like that they occasionally confuse each other. Actually, there is hardly anything you could do here that the people in England would not like, because they trust your motives completely even though your behavior seems strange to them sometimes. Inevitably they give credit to your motives. They are inclined to say, "This is a sound expression of something we don't understand."

I have found much the same attitude here about the people working in England and other places. This to me is an astonishing attitude, but it is an attitude that one is beginning to find in the field of health. For instance, in the case of the World Health Organization Interim Commission, whole sessions have been completed without the taking of a single vote. I have found the members agreeing on every question, no matter how controversial, by compromise and agreement. The membership includes the U. S. A. and the U. S. S. R., the Ukraine, Yugoslavia, the Netherlands, the United Kingdom, the Latin American countries, France, Egypt, India, China, Canada, and many others. They have never taken a vote on a technical matter, and they have rarely taken a vote on any matter at all. Even at the fifth session, they decided an extraordinarily difficult question—the place of meeting of the First World Health Assembly—without any vote,

after extensive discussion and starting with widely diverse attitudes.

This is an indication of at least two things: first, an appreciation of the seriousness of the world situation; second, a realization of personal responsibility on the part of the people who are concerned in international affairs, to make things work and work in a friendly and comfortable way.

We must care less for personal, individual, or national prestige than has been common in the past, because many people are finding that there are no differences between the way personal and national prestige works. Adult people do not need excessive prestige. They have their security in the ability to contribute to a common cause. This is being learned and must be learned much more extensively. In this assembly in London the opportunity arises to spread that point of view—the one that is represented by all of you here, who are capable of living in peace with a variety of kinds of people.

There is no possibility of any one group beating all the other groups into agreeing with their way of thinking. Many have tried; no one has ever succeeded. It is necessary for us to learn to live with very strange people—even as strange as we are. It is very difficult indeed for us to explain to other people in other nations what our motives are, why our countries have behaved this way or that, why our nations have done this or that, because we have not been thinking in the same frame of reference. Our difficulty is that we have been brought up in relation to one way of living—we did not learn early enough that there are other ways of living, all of them experimental, all unproven, none of them entirely successful. Our problem is not to defeat these other ways, but to improve our own way and show how good it could be if we could improve it. This is a fair way. If enough people can learn to live their own way of life competently—to show what happens if enough people live such a way of life—then there is no difficulty for the world in the end, because we will all be able to learn from what other people are doing as well as from what we are doing. We have not got all the answers in any country. We have much to learn from every experiment in living that has gone on anywhere. We are far from arriving at any final social goal.

In this congress and those that follow it, will be gathered a lot of people from very diverse situations, who have been brought up in different kinds of living, with a variety of disciplines and trainings, able to talk together in a cause common to all of them, though the cause may not yet be defined clearly. The people at the congress will not know yet where we are going. We must be able to look at the reality, to define a pathway at least a little way into the future, with some hope of being able to follow that pathway. There is a long way to go, but the first steps have begun—this congress is the biggest step that has ever been taken or can be taken at this time in the direction of people being able to live together in peace in a new kind of world.

A word about the headquarters for the World Federation for Mental Health. Because of the attitude that has been found among many of the people who are concerned about this great problem, it has been possible for some of them to suggest that the headquarters of the World Federation for Mental Health might be located in Switzerland. There is no vested interest of any kind concerned in that suggestion. Most people who are concerned with this matter do not care where the headquarters are and would be happy to have them here, in China, India, Siam—anywhere else. They are concerned that the organization should get along as well as possible in a most tumultuous world. They feel that if it can be located in Switzerland, there will attach to it less unnecessary emotional overtones that might make trouble than anywhere else they can think of. I believe the suggestion comes from as disinterested a motive as that. No individual is going to gain anything in prestige or anything else by having the headquarters in Switzerland.

CONSTRUCTIVE FORCES IN THE JOB *

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I AM limiting my discussion to constructive forces that already exist in the job. I am further limiting it to jobs in industry. And industry, in this sense, means manufacturing.

The reason for my first limitation will be obvious to all scientists. Forces are natural. They already exist. They cannot be constructed or destroyed. They may be misused or utilized, but that is the limit of our powers over them. And I am assuming that those who prepared this program had in mind the utilization of these natural forces when they assigned the subject.

My reasons for the second limitation are several:

1. All my experience for the past six years has been in industry. I can, therefore, talk about jobs in industry with some feeling that what I say will be factual.

2. Industry constitutes one of the most realistic situations existing in our modern world. As such it is a testing ground on which the strengths and weaknesses developed by the early training of individuals become clearly apparent. The reactions of men and women in this real world disclose faults and virtues of school and home as did army life during the war. They bring out, also, the factors that cause functional mental disorders in so-called normal people. Psychiatric observations of these factors should, in time, supply us with data by means of which we can diagnose important causes of psychiatric conditions and go on to develop effective measures for preventing them.

3. Industry has long recognized the same problems that confront us when we think about preparing for world citizenship. Industry has accepted the necessity for studying

* Presented as part of a symposium on "Constructing the Forces That Mold Minds," at the Thirty-eighth Annual Meeting of The National Committee for Mental Hygiene, New York City, November 12, 1947.

human relations and learning how to improve them in its own sphere.

In order to produce goods at a cost that makes them saleable in a competitive market, industry has to take the young men and women turned out by our schools and homes and mold them into teams that work together in some degree of peace.

The results of such efforts have been far from perfect. When you read about all the strikes, you are apt to feel that such efforts have completely failed. Actually, they have not. Few industries have been destroyed, as countries are destroyed in war, as a result of failures in human relations. Despite the flare-up of strikes, industrial managers have been able to reach agreements with their men and go back to work together as nations no longer seem able to do.

Other industries have had few or no strikes. They have been more successful in developing the good human relationships that are essential to good citizenship.

From the failures and the successes—both relative, neither perfect—we have much to learn about the factors that contribute to or that detract from good human relationships. Study of the failures should enable us to avoid practices that are dangerous; study of successes should high-light the essentials for good citizenship.

4. Industry learned a long time ago the need for trying out new methods and processes in a small way before putting them into production. Even the most valuable of new products and new processes are tried out, for months and years, in laboratory first and small pilot plants second before their value can be determined. Costly experience proved that some of the most wonderful-sounding ideas—in fact, many such ideas—fail to work in actual practice.

Despite disastrous past experience in world citizenship, a great many people still fail to realize this need for actual testing in the field of human relations. And, strangely enough, the greater the stakes in human life and happiness, the more prone we seem to be to risk everything again on some idea that looks bright, clever, wonderful!

There are, in fact, many people who take the viewpoint that anything that succeeds is wrong; anything different is right. Some of these insist that our own present system of

government should be torn down and replaced with something they claim is better. And they further insist that we should accept such dicta without any real evidence.

Such persons, please note, do not say there are faults in our present system that should be corrected. According to them, it is all wrong. Neither do they admit that there can be any faults in whatever new system they proposed. It—they claim without any proof—is perfect. And they resent any one who would offer facts that might prove them wrong in either case.

Industrial management makes no such claims to perfection, infallibility, or omniscience. Instead, it continuously seeks to find its faults, so that it can diagnose and correct them. More and more it accepts the truly scientific viewpoint that opinions are worthless when the facts contradict them. I am convinced that we must accept this viewpoint, the value of which has been proved in industry, if we are to become good citizens.

My own study of individuals in and out of industry discloses one unhealthy trait of normal, civilized men and women that appears important above all others in keeping us from acting as good citizens. Fortunately, it is not a natural trait. Wild animals do not exhibit it. The primitive people I once came to know had little of it and had found how to bring up their children with little or none of it. It is a product of civilization.

I refer to the marked tendency of normal, civilized men and women to indulge in flights from reality, to accept these as real, and to base important actions on them.

Now flight from reality has long been recognized as characteristic of functional mental disease. When we discover that a man reacts to the fixed false beliefs we call delusions, we begin to suspect that he suffers from a psychosis. If, on further investigation, we find that he believes himself to be omniscient, omnipotent, and infallible in his judgments and that he believes he is the Messiah with a call to save the world, we are satisfied that the poor fellow has developed what the layman calls insanity.

We come to the same conclusion with another individual who, without ever saying that he believes such things, begins to act as if he did. This man becomes physically and mentally

overactive, has a flight of ideas, and acts as if he had acquired all knowledge and all power. He shows an awareness of reality, but misinterprets facts. We say that he has "flown into reality," but actually he translates reality into unreality.

In either case we recognize the characteristic flights from reality of the mentally deranged. We have learned that the reasoning of such people is impaired and their judgments untrustworthy. We treat them accordingly.

What we do not accept and do not like to think about is the unpleasant fact that we normal people are also subject to flights from reality. We, too, have our delusions of grandeur. We, too, at times, develop Messianic drives to save the world and, as part of these, assume that we have developed knowledge which, if not superhuman, is certainly superior to that of other peoples.

The chief difference between us and the psychotic, then, appears to be that we agree to react to the same delusions in groups, while the psychotic insists on keeping his delusions individualistic and will not coöperate with others. Of the two, the psychotic is by far the less dangerous to world peace.

One small, little known item in the treaty of Versailles will show how dangerous such flights can be. Inspired by the idea of setting up democracies, we enthusiastically backed the Serbs in setting up Jugoslavia. We felt it was a very fine act and a just reward for the support they had given the Allies.

What we left out of consideration was the fact that we were giving the Serbs dominion over their age-old enemies, the Croats. The two groups had been feuding for many centuries. Our own mountaineer feudsmen, the Hatfields and McCoys, at least declared a truce to attend the same church; the Serbs and Croats had differed for ages on religion, policies, everything. And we—the Allies—married them off to live happily ever after in a government completely controlled by the Serbs.

Now, of course, the tables have been turned again. The Croats, with the support of Russia, are in power, grinding the faces of the Serbs into the dust. The Croats hate the United States and the other Allies in response to the treatment, based on our own flight from reality, that we imposed on them.

A similar flight from reality with regard to jobs themselves was developed and proposed toward the end of World War II. It was demanded that industry supply jobs for 55,000,000 workers the moment the war was over. This was based on the assumption that industry supplies all the jobs in the United States.

The facts were these: The highest percentage of our population that ever worked in industry during peace time was 6.7 per cent. Even in the midst of the war, when industrial production was at its peak, only 23 per cent of those employed were in industry. If industry, at the end of the war, had been able to hire 55,000,000 people, there would have been nobody left to run our farms, stores, railroads, utilities, and other services. The resultant chaos would have made it impossible for industry to operate, and there would have been jobs for nobody.

All such flights spring from the minds of individuals. They are then adopted, with little or no real thought, by others. And this latter phenomenon—the absence of searching, independent fact-finding and thinking—constitutes one of the greatest dangers to world peace.

Hitlers, *per se,* are no more dangerous to world peace than is the psychotic. What makes Hitlers dangerous is the readiness of masses of people to follow them blindly—even to their deaths.

But even so, Hitlers and their followers in other countries would not need to be too dangerous to us except for the existence of the same characteristic in us. The recent war could probably have been prevented, with comparative ease, if we had faced reality during the early nineteen-thirties.

But this we refused to do. We would not even permit ourselves to admit that another war was possible. We insisted, instead, that another war was unthinkable—that a man with a Charlie Chaplin mustache was ridiculous and could not be dangerous; and then, with complete inconsistency, we tried to appease Hitler as we try to appease our own spoiled children. By doing so, we evaded the issue at a time when a small use of force might well have stopped the catastrophe.

What makes people react this way? We desperately need the answer to this question before we can hope to learn how to be good citizens. Diagnosis must precede both treatment

and prevention or we are very apt to repeat old mistakes and kill a world suffering from a severe attack of appendicitis by administering another dose of castor oil.

What makes *us* react this way? Until we learn how to correct this tendency in ourselves and our own children, we are in no position to cure the ills of the world. To see clearly, we must first cast the mote out of our own eye.

This tendency to fly from reality, as study of normal people at work discloses, is nothing more or less than another symptom of functional mental disease. It is a product of exactly the same forces that produce psychoneuroses, functional psychoses, psychosomatic ills, and behavior problems.

If this be true, it throws the problem of building good citizens, whether these be citizens of a township, city, state, or world, squarely in the lap of organizations like The National Committee for Mental Hygiene. But it also throws upon us the responsibility to stop and examine ourselves and our own ideas, to make sure that we are not evading some of our own realities.

There are certain areas in which, I suspect, this may be true and I am going to mention two or three. If I am wrong, you can help me correct some of my own flights from reality.

1. We put too much emphasis on clever ideas *per se*. Young men, entering industry, often suffer intensely because they have been taught, in school, college, and technical schools, that bright ideas are at a premium in the real world.

Young technical men, for example, often become very much disturbed when they enter an industrial research laboratory and find that unproven ideas, by themselves, have little or no value. Some of the men become so emotionally disturbed that they fail completely.

Such tragedies could be prevented—as they are prevented in some homes and some schools—by maintaining a more realistic atmosphere in which bright ideas as such were not so highly rewarded.

The reality in the research laboratory is this: Bright ideas are common. The big problem is actually that of trying to determine, in advance, which of many ideas is most apt to repay the time and money required to test them out.

Because this is true, there naturally develops a custom of testing out new men. And the criterion for such testing is

by no means the brightness of their ideas, but how realistically they attack the problems assigned them. Only after they have demonstrated productive ability will any one pay much attention to their ideas. Men of ability, who accept this reality, usually get ahead. Some go to the top.

If, in the world at large, we learned to judge ideas and men in terms of the results they produce in their daily work instead of on their ability to sell ideas, I believe we could do much to produce better citizens and a better world in which to live.

2. When men have produced results in one field of endeavor, we tend to assume that they are experts in all others, whether or not they know anything about such other fields. This can be highly dangerous. Hitler may have been an excellent paper-hanger. He undoubtedly was an excellent salesman of his own ideas. But ability as a salesman should not be accepted as proof, in itself, that such a salesman has demonstrated the quite different qualities required in a good ruler. Yet we react as if they had, over and over.

In industry we are beginning to learn to guard against this dangerous habit of thought. An excellent craftsman may, and often does, make a very poor foreman. So, when it comes time to choose a new foreman, every effort is made to choose the man who has proved, in his past human relations, some ability to get along with other men and to get them to join in a team to produce something worth while.

I am touching here on a formula for success and its rewards—another flight from reality—which we seldom verbalize, but which has tremendous influence in leading us into difficulties.

It seems to be a common delusion that success in any line confers some sort of omniscience in all other fields of knowledge and endeavor. The prospective mother commonly expects that when she achieves motherhood, she will become a different kind of being and "know best" about everything pertaining to children. The successful man in business or in a profession often acts as if he believed that his success in one field had conferred omniscience about all the material problems in the world. And we react to the same formula by accepting atomic scientists as authorities on statesmanship.

It was on this basis that the United States was led into

making one of the best generals we ever had, Grant, into one of our worst presidents. And it is now on this basis that, I fear, psychiatrists and others with no experience of any sort in government are assuming omniscience in world affairs. Some of these people approach industry almost daily to tell successful managers how they really should run the business to succeed!

This type of flight from reality will continue to be prevalent until, in our own schools and homes, mothers and fathers cease to react to it. For, as long as we continue to react to it, our children will follow our bad examples and the disease will increase.

This increase will continue to give us the highest insanity and crime rates in the world. In the face of these last—clear evidence in themselves of our own failures as citizens here at home—I cannot believe that we are ready to offer our way of life, *in toto,* as an example to the world at large.

3. Everybody, these days, is thinking about security. And we should be. But the very importance of security should make us take special care to be realistic in our thinking about the subject. To depend on a life raft and then to find, when the ship sinks, that the raft is unseaworthy is disastrous.

Feelings of insecurity produce many problems in industry. Some industries have gone far in supplying material security for their employees. In government, civil-service practices attempt the same thing.

But this approach to the problem fails to relieve the *individual's feelings* of insecurity. It fails so often that we may begin to suspect there is no relationship between material security and the inner feeling of security. Psychiatrists with wealthy patients should know this.

I am convinced that it is true. I saw and lived, years ago, among aboriginal Indians and others living in a state that we would consider semi-starvation, in constant danger from the perils of the jungle and tropical disease, who showed every evidence of enjoying a state of feeling secure almost beyond the conception of civilized people to-day. A recent article about the Marshall Islanders emphasizes the same point.

Such observations aroused in me a special interest in the subject of security. And further study has led me to conclude:

Security, the feeling, is a state of mind. Feelings of inse-

curity are another symptom of mental disease, common among civilized normal people.

Promising to relieve feelings of insecurity, by material means, gives temporary hope and relief, but ends up by creating bitter resentment. The recipient finally reacts as if those who promised relief had deliberately deceived him. And the bitterness of such recipients against their alleged benefactors is far greater than it is against those who never pretended to try to help them. Russia seems to know this.

If this be true, the attempt to relieve the feelings of insecurity by material means may be one certain way to create future enmities. I have seen many individuals in whom such enmity had developed on this basis.

On the contrary, a very different approach seems to produce good results. So far as I can observe, the one thing that cures feelings of insecurity in individuals has been any proper, fair, legitimate means of getting them to realize that no one but themselves could solve their problems for them. Then, second, to get them to settle down and meet their own responsibilities face to face and solve them for themselves, by their own methods, as best they could.

Out of this latter approach, the individual gains in self-confidence, feels more satisfied with himself, and gains increasing feelings of security. In this new state of mind, what actually happens to him materially becomes, strange as this may sound, less important to him than the way he meets and handles it. Then—and I suspect only then—can he enjoy a sense of security in this mad, changing world in which we live.

I am indebted to a discussant, whose name I missed, for the added statement that there can never be, in this world, permanent security in the material sense. No matter how many other dangers we may escape, we must each finally die. Permanent material security will always be a myth. Only when we realize that it is a myth, can we find and enjoy feelings of security.

Other discussants attempted to misconstrue my remarks into a condemnation of the desire for material wealth, comfort, and such security of this sort as may be attained. I said no such thing.

Gold, and all it can buy, is very nice. Lack of gold can

be very unpleasant. But neither billions of dollars, nor complete poverty, nor any amount of material wealth between these two extremes can, in themselves, cure or prevent mental disease. And the usual common feelings of insecurity are manifestations of our own mental disease.

To conclude, it seems to me that the starting point, in any realistic approach to world citizenship, is with ourselves. Our first problem is that of discovering means whereby we can live in peace, each of us with himself in his own mind and heart. This is a state of mental health.

Until this has been attained, the individual will be driven by pathological Messianic drives to make the world over to conform to his own flights from reality, fully believing in the delusion that this will make him happy.

I further believe that once we have made peace with our own natures, we will discover that we no longer infect our children with mental disease. We will no longer drive them into the inner conflicts of which warfare is merely one reflection—one manifestation. Then—and only then—will we be ready for world citizenship.

CONSTRUCTIVE FORCES IN THE HOME *

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A FORESTER counting the annual rings that tell the life story of a fallen tree can often distinguish narrow, irregular, and crowded lines that bear witness to years of stress and privation. If the past history of our nation could be recorded in the fashion of a tree, it is safe to say that the register of events during the past two world wars would appear as bands similarly distorted and malformed, testifying to the influences that affected the development of this country and that of practically every other group of people in the world.

The institution of the home was affected in many ways by the catastrophic events that occurred in these war years, and there is now general agreement that if humanity is to survive, the recent era of destruction must be followed by reconstruction and reorganization, focusing on the home, on family life, and on the interpersonal relationships of children and parents. Although this demands the serious attention of all professional groups that deal directly or indirectly with questions affecting family life, the present exposition will be limited to consideration of the rôles of the physician and the nurse in promoting constructive forces in the home that will help to mold the minds of children.

It does not take the trained eye of a historian to note a parallellism between the changes that followed the first world war and those that have come after the second. A chapter from a history describing the post-war period from 1919 to 1929 reads like a daily newspaper of 1947. For example, scanning the pages of Preston W. Slosson's book, *The Great*

* Presented as part of a symposium on "Constructing the Forces That Mold Minds," at the Thirty-eighth Annual Meeting of The National Committee for Mental Hygiene, New York City, November 12, 1947.

Crusade and After, 1914–1928,[1] one finds statements about the home that are apt to-day:

> "The war struck a serious blow at domesticity by restricting the labor available for house building. A crisis in housing naturally resulted and, before new construction after the war could overtake the demand, rentals soared to unheard-of figures. New York City apartments that for many years had cost forty or fifty dollars a month increased suddenly to one or even two hundred, and the state legislature was forced to adopt emergency laws to prevent the eviction of thousands of tenants who could not meet the new rentals."

One might cite other examples, notably the rising cost of food, the high divorce rate, and the paradox of increased juvenile delinquency in a society in which there was an increase in church attendance.

Yet in spite of the similarity between present trends and those after the first world war, one is impressed with the difference in degree of magnitude not only between the warfare of the second world war and that of the first, but between the events in the post-war periods of the two. The changes we are now experiencing seem more extreme, and appear to develop with greater speed and in greater force. The decade after the first war seems to have reappeared in a compressed, but unabridged form in the triennium after the second war.

Each of the last two world conflicts gave impetus to the development of psychiatry in this country, but here again there is a difference in degree of change. This audience need not be reminded that the child-guidance clinics were established about 1920 by The National Committee for Mental Hygiene and the Commonwealth Fund, chiefly for the purpose of studying and treating pre-delinquent and delinquent children. These clinics, although conceived with a limited purpose, have gone far beyond the aims of preventing and treating delinquency.

In appraising the development and contributions of child-guidance clinics, Stevenson and Smith,[2] in 1934, concluded that "the child-guidance clinic is more than a therapeutic agency. It is a tool for synthesizing the most promising approaches to problems of behavior and personality in child-

[1] New York: The Macmillan Company, 1930.

[2] See *Child Guidance Clinics*, by George S. Stevenson and Geddes Smith. New York: The Commonwealth Fund, 1934.

hood, and for demonstrating the synthesis to the professions concerned with those problems. It is a laboratory in which new leads may be found for the study of the child. As such it has a place in social evaluation." In this critical review of the child-guidance movement, Stevenson and Smith pointed out that the hypotheses on which these clinics based their programs were "fluid," and that many of the observations of child behavior on which they were based were too recent and too experimental to justify their adoption and use by pediatricians, nurses, teachers, social workers, and parents.

Other authors in the field of psychiatry have felt the same way about advances in psychotherapy not practiced in a child-guidance setting. Flugel,[1] in his psychoanalytic study of the family, expressed the belief that the healthy mental development of an individual depended on a healthy family life, yet added a note of warning against general acceptance of this concept because of the paucity of psychological research, clinical observation, and experimentation in these areas.

Although medical psychology and psychiatry in this country received impetus from each world war and bridged the interval between them, the second war also stimulated a movement in medicine, particularly in pediatrics, and in some aspects of nursing, that, in the 1930's, seemed to rise independently of the child-guidance movement and mental-hospital psychiatry, but ultimately fused with each of these. I am referring to the sporadic, and apparently spontaneous, awakening of interest in the psychological aspects of medicine and nursing, which appeared first in scattered areas of this country, but which now has become a movement of force in medical and nursing education.

As a consequence, it may be stated tersely that American medicine and nursing have rediscovered the *individual* who as a sick or a well person comes for help, and the setting in which he is born, is reared, and grows—the *family*. This discovery is having widespread effects. Among other results, it has helped to validate some of the psychological principles set forth by medical psychologists such as Flugel, who ventured their hypotheses with belief tinged with scientific skepticism.

[1] See *Psychoanalytic Study of the Family*, by J. C. Flugel. London: The Hogarth Press, 1931.

To the psychoanalytic group of clinical observers should go the greatest credit for emphasizing, even before the first world war, the importance and nature of family life in causing or preventing psychological problems in the individual. This theme has been taken up by workers in child psychiatry, particularly psychiatrists, psychologists, and social workers in child-guidance clinics, and it has become obvious that the psychological atmosphere of home life, with complex emotions aroused by and inherent in the various family relationships, influences fundamentally the development of the personality.

Clinical study of children and their parents as part of the multiple treatment in child-guidance clinics has produced evidence that the psychological maturation of an individual is dependent in large degree on the child's relationship to members of the family circle and on the position that he has taken or has been forced to take in regard to problems and difficulties arising within the relatively narrow world of his family. As a consequence of work done by dynamically oriented psychiatrists with both adults and children, it is evident that certain main principles of personality development have emerged to demand the serious attention of all of us who deal with children.

Since even a brief review of these psychological principles at this time would be time-consuming, and might lead to irrelevancy of discussion, this thumb-nail characterization of the growth and development of infant and child is offered as a preamble to an account of how persons in medicine and nursing are revitalizing their fields of work in child care and helping to activate forces in the home that mold the minds of children.

Growth must be viewed as a living, changing, organic process which proceeds biologically within a framework of relationships and experiences that direct and give meaning to the developing self. Growth of an individual may be viewed as following a broad biological pattern, yet also as a narrow design based on personal family heredity and proceeding as a process of individualization of the self in the setting of the family unit. Allen[1] has called this differentiation of

[1] See *Psychotherapy with Children*, by Frederick H. Allen. New York: W. W. Norton and Company, 1942.

the individual the central core of growth, and has emphasized the importance of this ingredient as essential, not only for the healthy development of every child, but also for therapeutic benefit of individuals in psychiatric treatment. The term "identification" has been employed to denote the closeness of the ties of the infant and child to his parents. Without the opportunity or the capacity to feel related to parents, without parental patterns to emulate or to organize his own powers around, the child does not grow in an integrated manner.

Recognition of the fact that the conception and birth of a child bring a realignment of feelings in a pair of prospective parents, and realization that the quality of the emotions in these people, as they assume the new status of father and mother, determine in large part the ease or the difficulty of child rearing, have only recently come to physicians and nurses engaged in child care. That the professional rôles of these groups may help or hinder parents develop adequacy to function in their new rôles, depending on the character of the interpersonal relationship of physician (or nurse) and parent in the pregnancy and early-infancy periods, is becoming increasingly clear to practitioners of modern medicine and nursing. And although it is recognized that the laws, customs, and taboos of each cultural group play important rôles in modifying attitudes toward child rearing, there is growing belief among physicians and nurses that they have unique opportunities for helping children grow by assisting parents achieve a maturity of their own through the processes of parenthood.

At this point, evidence should be produced to support the thesis that there is an awakening of the medical and of the nursing profession to their opportunities in mental hygiene. Examining first the records of medical and nursing education, one finds greatest progress at the postgraduate level. Fostered by such private foundations as the Commonwealth Fund and the Rockefeller Foundation, long-range enterprises in research, in the teaching of psychiatry, and in the integration of psychiatry with pediatrics and internal medicine, have been carried out at several medical schools in this country. Fellows in training have been chosen for intensive study and have then gone out into their respective fields in order to

cross-fertilize the thinking of professional and lay groups both within and outside of other medical centers.

In time there has been a sifting and a filtering down of concepts to other levels within each medical group, the undergraduate level receiving a measure of influence. At times these processes of education have seemed too slow and inadequate, and this belief has stimulated leaders in medicine and the staffs of philanthropic foundations to venture experimentation in brief conference seminars and in short-term group teaching.

Examples of the first of these teaching programs are the Conferences on Problems of Early Infancy, sponsored by the Josiah Macy Jr. Foundation [1] and held for the purpose of bringing together representatives from obstetrics, pediatrics, psychology, and psychiatry, for discussion of a multidiscipline approach in solving basic problems in child care. These conferences have served as clearing houses for discussion of growth and development, of infant feeding—particularly breast feeding, of the rooming-in arrangement in newborn care, and of the influences of maternal attitudes in the neonatal period.

Other important foundation-supported teaching projects that have had significant and widespread influence were those arranged by the Commonwealth Fund. The first of these, in 1946, considered the topic of "Psychotherapy in General Medicine." [2] Twenty-five physicians met at the University of Minnesota to participate in a course designed to serve as an experiment in teaching physicians in general practice about the human personality and the place of the practitioner of medicine in assisting its development and in preventing and treating deviancy. The play of forces within the personality and between persons was the central theme. The results of the experiment seemed to be that the participants returned to their practices with a feeling of greater personal worth to their patients and with a "determination to put more time and more humanity into their contacts with patients."

[1] See *Transactions of the First Conference on Problems of Early Infancy.* New York: Josiah Macy Jr. Foundation, 1947.

[2] See *Psychotherapy in General Medicine,* by Geddes Smith. New York: The Commonwealth Fund, 1946.

A second project of the Commonwealth Fund had a stimulating influence on pediatric education. In 1947, at Hershey, Pennsylvania, a group of teachers of pediatrics and practitioners of that specialty met with psychiatrists and social workers to share ideas about the growth and development of children and to collaborate in discussing and planning ways of enriching pediatrics as an instrument of child care and child study.[1]

It was pointed out in the conference that a new definition of the function of the pediatrician, or of any one who practices pediatrics, is in order; that whoever takes over the responsibility of child care is taking on a comprehensive obligation for supervision of the growth and development of the child; and that this involves creating better interpersonal relationships at various levels, particularly those between the child and his mother, the child and his father, among the members of the whole family group, and between the physician and the family.

Again in this conference the psychological aspects of patient care came to the fore, and it was emphasized that when the patient is an infant or a child, attention must be focused on ways of promoting parent-child relationships, beginning in the newborn period through a more humane management of mother and baby, as exemplified by less coercive and rigid methods of feeding and other care.

Simultaneously with the development of greater awareness in medicine of the rôle of psychological forces in shaping personality, came similar recognition in nursing groups. It is not clear how the movement in the one profession affected the other, but they have become mutually stimulating. Individuals as well as separate groups in nursing education, in hospital and in public-health work, seemed independently to have come to the same point of view—the sense of the need to understand the interaction of physical and emotional factors in everyday health problems and the turning to medical psychology for concepts of mental hygiene, in order to comprehend the hazards in family life that may wreck the lives of growing children.

At times the nurse with this new insight has taken a further

[1] The proceedings of this conference are to be published by the Commonwealth Fund.

step, in learning about herself and how her attitudes and reactions to people help or hinder her in her care of patients. This step of professional and personal maturation is often accompanied by another—the ability to work effectively in team relationships both within nursing and in association with allied agencies outside that field.

Instances of these changes in the philosophy of nursing were few at first, but are now numerous. Although tribute is due to certain women who were pioneers in their field, and who are responsible for the widening trend in nursing care that embraces psychological consideration, mention will be made only of some of the instrumentalities that are carrying on their ideas in workable fashion. Some centers of nursing education are in the fore and, through postgraduate teaching programs, are reorienting the nurse in terms of mental hygiene integrated with physical hygiene. Teachers College, Columbia University, may be singled out in this respect as having far-reaching influences, in as much as graduate nurses go there from all over the country for this type of refresher training and return to their local communities to stimulate new thinking in local departments of health and in hospital and child-care centers.

The National League of Nursing Education has recently sponsored a pediatric-nursing study initiated by the United States Children's Bureau and carried out at the New York Hospital.[1] The purpose of the study was in part to find out what constitutes adequate nursing care of children in specific situations. It is significant that nursing activity was found to imply physical care *combined with* psychological consideration. The psychological components, although recognized as less tangible at times than physical components, were (in this study) considered as basically important, since they "contributed immeasurably to the content, satisfaction, and growth of children and to their ultimate recovery." It was concluded that "the practice of good psychological together with good physical care lends distinction to pediatric nursing and makes of it an art."

The National Organization of Public Health Nursing, through its committee on mental hygiene, is fostering the

[1] See *A Study of Pediatric Nursing.* New York: The National League of Nursing Education, 1947.

training of nurses for careers as mental-hygiene consultants in hospital and community settings. This seems to be a training venture that embraces nursing, public health, social work, and medical psychology, and although the end product would be a nurse who had specialized in mental hygiene, her function would not be to recruit other nurses for such hybridism, but, on the contrary, to aid nurses in integrating psychological concepts with those of physical care, in using existing psychiatric and psychological diagnostic and treatment services and other appropriate community agencies, and in increasing and implementing knowledge of human behavior and of personal relationships.

Noteworthy experimentation in developing mental-hygiene components in public-health departments and in carrying on in-service training programs in mental hygiene for physicians and nurses has been fostered by United States Government agencies, particularly the Children's Bureau and the United States Public Health Service; by state-government groups, notably maternal and child-health divisions; and by private foundations, individually or in coöperation with the other agencies mentioned. Connecticut, Maryland, New York, and more recently California have led in such endeavors. The results have been fruitful in improving child-care practices, particularly in well-baby and well-child conferences, through giving psychological insight to persons whose job is the guidance of parents.

Present-day students of human personality have all emphasized the need to provide growing children with a sense of security, which is fostered by sympathetic child-care techniques carried out by parents who have a feeling of confidence in themselves and who are able to convey this feeling to their children.

In the foregoing discussion of the responsibilities of medical and nursing groups in child care in the family, it was assumed that children have families. Obviously this assumption is not valid for all children. Many children have suffered war casualties in this respect, even in the noncombatant areas of our country, through disruption of family life, temporary or permanent loss of one parent or both, or parental disharmony. The rearing of children traumatized in this manner entails special consideration from all the persons engaged

in their care, but the physician, the nurse, the social worker, and the educator must first have a realization of what constitutes the ideal *milieu* for child development. With such a base line, the professional person can better improvise and arrange substitute measures which, although not ideal, can more nearly approach the approved standards. For example, care of children in day-care centers, while not the psychological equivalent of care provided in a family unit, can be made more like such care, if the size of the group is limited, and if the person in charge of each group understands her function as one of mother substitute rather than of custodian.

With funds provided under the National Mental Health Act, the United States Public Health Service is following through on a wider front with projects of professional education, research, and community service, which will enhance knowledge about children and strengthen child-care practices both within and without the home. Isolated areas of community and state experimentation should in time be brought together as a result of this widespread assistance from the federal government and because of recognition of the need for mutual planning. It is conceivable that this state of accord may be followed by one of even closer relationship between the disciplines of medicine, nursing, social work, and education, in as much as each of these is concerned about the welfare of the individual and each has to come to a realization of the influence of its specialty on the forces in the home that mold character and personality.

PSYCHIATRY AND THE SOCIAL ORDER *

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IT may well come as a surprise to many that a psychiatrist should be asked to talk with you about the world in which we live—a psychiatrist, rather than, let's say, an economic geographer or an historian or perhaps a ubiquitous correspondent just fresh from travel over widespread areas of the world. I should like to believe that this choice speaks for an increasing awareness of the fact that, in the last analysis, it is people who make our world and surely people who make it troubled.

True enough, it has not been long since psychiatry emerged from the shadows of the insane asylum and the jail house. It was as late as the end of the eighteenth century when the French physician, Phillipe Pinel, cut the chains that bound the insane patients in the Salpêtrière, and it was not so very long ago that Londoners on a Sunday holiday could, for thruppence, see the madmen at Bedlam, an institution whose attitude toward the mentally ill has, for all time, been fixed in our common English usage.

It was only very gradually, then, that psychiatry left its preoccupation with madness and shed at least some of its ancient beliefs in demons and sin. Now for the most part psychiatry is concerned with the problems of quite ordinary people and the world in which they live. In fact, the people who come to us for help reflect in a special way the confusions of the troubled world and represent, really, people whose inner resources and competence are no longer equal to the task of contending with the strifes and conflicts and anxieties of their—of our—world. We see infrequently, at least in our

* An address, slightly revised, presented at the Spring Institute of the Women's Division of the Federation of Jewish Philanthropies, New York, May 20, 1947.

consulting rooms, the deranged, the deteriorated patient of classic insanity; we see, rather, the anxious, the perplexed, the frightened and insecure people; the people who cannot resolve their problems and who have sought refuge in symptoms and given up the struggle in sickness. And so the psychiatrist has become inevitably the social scientist and has been required to enlarge his horizons from the bedside to the world in which he and his patients live and struggle.

The psychiatrist is a student of human behavior and is concerned with questions of the motivation of such behavior. He is concerned with trying to understand what makes people "act that way" (to desert our technological lingo) and with the factors in human lives that make for emotional pain and misery. There was a time when we looked almost exclusively for answers to things going on within the human himself and emphasized his heredity and his constitution, but had almost separated him, as a person, from the world in which he lived. Psychiatrists were preoccupied with the family tree and the bacterial flora and the body structure of the individual, but little with his job or his house or his earnings. Happily, that day is now past, and while no psychiatrist would ignore those hereditary and constitutional factors that might in a given instance be of importance, he is now ever alert to the problems of social adjustment and environmental stress which influence the individual so greatly. While we lean heavily on the complicated sources of human difficulties that are to be completely understood only in terms of unconscious conflicts, we have no longer isolated the human whose unconscious struggles we are endeavoring to understand from the world in which he eats and breathes and loves and, in the end, must die.

And so, as our understanding of the dynamics of human behavior increased, it was but to be expected that there should be greater demands on us to function in many areas far removed from ordinary clinical problems—in marriage counseling, in education, in industry, in the understanding of crime and war, and, indeed, in so wide a range of human endeavor that, confessedly, we are a bit bewildered at the demands upon us and more than a little hesitant and modest as we approach them. Increasingly, it seems certain, the

psychiatrist will function as a social scientist, and it is in that rôle that I would talk with you now.

The world in which we live and which influences us as people and about which we are speaking may best be understood as many worlds, ranging all the way from the inner world of self to the fairly abstract world of energy. It must include the world of our desires and needs, of our dreams and disappointments, of our goals and ambitions, our loves and our hates. At another level it may be the world of our avocations: the dark room of the camera bug, the collector's bookshelf, the baseball fan's concern with batting averages. There is the world of our social interests: the clubman's committee, the devoted director's agency preoccupation, the politically minded party devotions. There is another world of the group: the church, the Rotary, the Academy of Medicine, the veteran's organization. There is the vital world of the family: parents and children, brothers and sisters, husbands and wives, nursemaid and family retainer, the elevator boy and the cook. Still another world in which we live is that of the job: the mother's household, the professor's classroom, the artist's studio, the case-worker's consulting room, the teacher's class, the cop's beat, the broker's world of fluctuations and uncertainties. There is the world of our nation: "My country, right or wrong." There is the new world of internationalism, a frail infant, smothered almost at birth in the heavy cloaks of nationalism. There is, at last, the great world about us—of stars and distant planets and strange exotic lands and budding in spring and, for all time now, the world of the atom and its unleashed and yet unmeasured forces.

In a sense it can be said that each one of us must function and make an adjustment and, hopefully, succeed in each of these worlds if we are to succeed as human beings. We may modify the patterns as we will, distribute the expenditure of our energies and skills and talents to our own individual tastes, but for the complete human it will be necessary that he meet each of these worlds and, in one way or another, learn to live in them.

Surely this is a complex situation into which we individuals are thrust, torn from cradle to grave by varying and confusing uncertainties. And of the problems that these various

worlds present us, there seemingly is no end. Let us look at some segments of a few of these worlds and try to evaluate their influence on us.

Since you to whom I am speaking are women, I thought I should like first to talk a bit about the rôle of women in our world and examine some of the changes that have occurred in that rôle. The very fact that we are here together is as striking an indication of that changing rôle as I could find in my quest for illustrations. As I understand it, you, each of you, however different in kind and degree your participation may be, puts aside your household chores to participate actively in the destinies of one or more agencies that function under the ægis of this federation. It would be presumptuous of me to try to estimate the richness and importance of that contribution; truly it may be said to be inestimable. From my own experience as a board member, I have always felt that of the other board members (and they luckily included a large number of women) it could well be said, as of the postman, "Neither snow nor rain nor heat nor gloom of night stays these couriers from the swift completion of their appointed rounds."

Obviously this is a part of the now well advanced, if not yet completed, movement toward women's new rôle in the new world in which we live. Florence Nightingale lived only in the last century and did not die until 1910; Dorothea Dix brought the balm of her wisdom and womanhood to the mentally sick in the middle of the last century; and both of these women were, only so recently, to set the world aghast by their invasion of the world beyond home and garden.

It is not only that woman's rôle has changed, but with it the entire concept of the family has been altered. In the rural society of the days before the industrial revolution, the family was a compact unit of home and production. A woman could bear and raise a family, spin their clothes and cook the meals, tend the sick and teach the young, all under her own roof. Only the call of charity to a stricken neighbor took her into the community. And to share the discipline and the learning and the important religious observances and lessons, the father was never far from home and the security of his presence was always about.

The industrial revolution was to change all this, and urban

civilization was to see an entirely new type of family structure. Nor can it be said that even rural living has in its basic elements remained unchanged.

In the first place, the combination of the home and the productive unit exists only in extremely rare instances. The man goes to work and is away all day; the family is increasingly the woman's to train and educate and discipline, as well as to bear and nurse. The family seems to be less and less the father's responsibility and the effects of this are profound and complicated, especially in terms of the influence on the children in the home.[1]

But of course the revolution has extended far beyond this. Woman is now, for the first time, brought into conflict as to her rôle in the world, and in some measure every woman is confronted with the choice between her rôle as mother and her rôle as individual. Employment and educational opportunities have continued to increase, and even though we are still far from full equality (equal pay for equal work, for instance, still remains a goal to be reached), the tide surely runs steadily in that direction. This process was, of course, immensely catalyzed by the war and women found themselves, for the first time, truly part of the machinery of war.

And along with it have come technological improvements that make it increasingly simple for women to try to combine home with professional and industrial careers. All of these things—electricity, the telephone (though I am never quite certain that the telephone really has liberated us and not, in truth, enslaved us), modern methods of food preservation, and so on, and so on—have sped a process and precipitated a crisis.

I should not like to be thought a disciple of Hitler's "*Kinder-Kuche*" concept of woman's place in society, nor do I share the fear of some of my colleagues that woman is the lost sex, but it would be shutting one's eyes to the truth not to face the fact that complexities and conflicts often result from this liberation, whatever its great and manifold advantages have been. Certain it is that divorce is vastly on the

[1] A friend (a young grandmother) in the audience objected to this. In her experience, especially with young fathers who are veterans, she observes an increasing willingness and desire to share this responsibility and to devote a large part of their leisure to the pursuit of "old-fashioned" fatherly tasks.

increase—there is now one divorce in every three marriages—and marriage is the especial province of woman and the root of her security. And the tensions of our family lives must bear some measure of responsibility for the alarming rise in the rate of childhood emotional problems and delinquency, though obviously the problem is far too complex to allow of the simple explanation that the cause is entirely the disruption of the family through the preoccupation of women with careers and pursuits outside their homes, as has been claimed. It is indeed curious that just those who believe in this explanation should also adhere to the current oversimplification that blames practically everything on "momism." How easily we are beguiled by that easily mouthed term!

A second great impetus to this change in the rôle of women came from what may perhaps be called the Freudian revolution, or the rise of the modern dynamic concept of the rôle of sex in our lives. Much nonsense has been spoken and written about this great man and his works, and much silliness is still believed about him. While the shallow adaptation and distortion of his ideas in fiction and art and the motion picture have made his name and his works a commonplace, this familiarity often cloaks the greatest degree of ignorance and misunderstanding. Interestingly enough, Freud himself, in discussing psychoanalysis in the United States in a different connection, said that he was afraid that Americans, with their accustomed enthusiasm, would promote its mushroom growth here and that popular acceptance would come before adequate understanding.

Be that as it may, Freud ranks with Darwin and his concept of evolution, and with Marx with his dynamic explanation of economic and social change, as one of those rare "intellectual discoverers" who contribute not merely specific discoveries, but an entirely new point of view which brings about subtle and far-reaching changes in the way people think and act. The impact of psychoanalytic thinking on our civilization cannot be overestimated; it has helped tear aside at least some of the pruderies, the false modesties, the hidden and distorted notions about people, their bodies, their functions, and their pleasures. If in truth we still falter on our way, we at least have set our feet on a road that must one day lead to a truer understanding.

But like all freedoms only recently won and still precariously held, this, too, has had its purchase price. Women can no longer as easily assume the rôle of clinging vine and seek the illusion of security that belonged to the "weaker sex." Nor is it only the woman's claim to a seat in the bus that has been surrendered; equality, even though it be not by any means complete, requires of her that she measure up to her newly gained rights and privileges. This is not easy; the ancient forms, sanctified by long usage and often entrenched behind religious forms and cultural patterns, are not easily dislodged. Have you, for instance, noticed how often it is the woman who says of another woman and by way of sincere praise, "She plays golf, she drives a car, like a man"? It is by no means only men who speak of the "career woman" as if that were a term of derision; I have often noticed that it is women who, by and large, distrust women professionals.

Several consequences of this attempt to escape from the ancient bonds that women found intolerable should be mentioned. Of primary importance is the shrinking size of the family. Urban families have an average of one and a half children as against the two and a half or more children our grandparents had. This has many effects: it tends to heighten the preoccupation of parents with each child, and is at least one factor leading to overprotective attitudes. In the larger families of previous generations, there was the protection and security of aunts and uncles and myriads of cousins, and much of the responsibility for younger children could be shared with older siblings. The sitter is largely a device demanded by small families; the sitter of other days was a big sister or a young aunt.

One of the most difficult rôles of our urban civilization is played by the young mother of a young child. On the one hand, she has all the ancient responsibilities to cook and sew and care for her child; on the other, the insistent beckoning of outside activities, especially of interrupted careers, make an adjustment at the level of mother-housekeeper-wife very difficult. Nor have all the husbands who mouth acquiescence or even enthusiasm for their wives' careers by any means really made peace with the situation. This is especially true where the woman's earnings are the larger. Often

there is much stress in the marital situation resulting from this shift in values.

There are many other facets to this problem. Suffice it to say that woman is caught in a complicated biological-psychological-cultural turmoil and is, as a result, often restless and unsettled—partially free, yet insecure in her freedom and not yet by any means accustomed to it.

But we must hurry along. There was a time when things were ordered more simply, or so it seemed. A man did his job and saw the end product of his work and knew the security of his home and the stability of his market; his friend was the provider of the raw materials and the purveyor of his goods. One of the most basic changes in the world in which we live has been occasioned by the technological advances that make it increasingly rare for that set of circumstances to exist. The age of specialization has now so far advanced that only a small percentage of our urban community can possibly know the supplier and the purveyor and the consumer of their goods, or, in fact, any of them.

The satisfaction of a job is a highly complicated matter, and although it is obviously of the most basic significance and importance, very little indeed is known about it. We usually say that we work because we must work, and necessity is certainly for almost all of us part of the story, but hardly ever all of it. I remember very well listening to the father of one of my patients boast of the fact that he did not work and tell of how he spent his time "following the sun around." Deep-sea fishing in tropical waters, salmon fishing in northern waters, big-game hunting, and the casual swimming at Capri—it occurred to me that really he worked as hard or harder at his fun than the worker at his bench. I ventured to query him about this, and after a moment's quizzical contemplation, he readily agreed that "there was something to it."

Part of the pleasure of work is the planning, the challenge faced and met, the actual motor activity of the job. In most of these directions, modern technology has reduced the gratifications of work, but it is in still another area that we have been most seriously deprived. If you give a group of children a task to perform, no matter how senseless and disagreeable, and if you permit them to complete that task, the

end result will be pleasure and satisfaction. If, on the other hand, you give them a pleasant and purposeful job and interrupt them *before* it is completed, they will feel miserable and dissatisfied and frustrated.

Thus, experiment recapitulates much of what technological advance inflicts on the host of our workers—the partial job, the incomplete performance, the sectional rôle a given worker plays. A man who tightens a bolt or sketches part of a drawing or does a bit of experimentation, often not knowing even what the total goal is to be, feels miserable and frustrated and, no matter what his recompense, is in some measure constantly defeated in his quest for work satisfactions. We all know the unrest that agitates us when, for however valid a reason, we must put off a task in which we are engrossed to take up another, even though it may be more interesting and important. I have often thought that, however much an executive, let's say, may suffer from such confusions, they are as nothing to this phenomenon as it occurs in the life of a busy nurse-companion-tutor-cook-housekeeper-wife-mother. How important such factors are in industrial unrest and workers' tension can only be conjectured, but we feel certain, from the evidence available to us even now, that it is a tremendous force making for tension and lack of satisfaction, and not only in industry, but everywhere in our current society.

I always remember with the keenest pleasure an old carpenter who worked on the balustrades of a building that was being constructed at a hospital in which I was a resident. I can see him so vividly, now twenty years after, as he stepped back from his handiwork, his face breaking into a cracked smile of sheer joy and pride of workmanship. I not only learned much psychiatry from watching him, but it is to him and to my patient's fisherman father that I owe the beginnings of my long interest and continuing study of the complex problem of occupational choice and adjustment. And it is with them that I contrast, for instance, a man I know who has a wonderful job: he is in charge of the inland water traffic of a large corporation. He has one constant complaint: if only he could see the damn' boats and not just move them around on maps that hang on the walls of his office! It is not only the traditional bolter on the automobile

belt line who knows the frustration of monotony and the piece job, and never the joy of the whole job brought to fruition.

We have now glanced at two important changes in the world in which we live—the changing rôle of woman and the frustration of modern, technologically improved industry. I should now like to move into two sources of tension, potential and real, which are intimately connected with those we have been discussing.

The first of these is the rôle of the veteran. It seems quite extraordinary to me, and a little shameful, how quickly we have shunted the problem of the veteran from our consciousness, with an avidity born, no doubt, in some measure of feelings of guilt and disappointment in the fruits of our victory. But the problem of the veteran, once on every one's lips and in every head line, will not be so lightly disposed of, quiescent though it seems. Let us hope that we will not always need still further armed seizures of government to remind us that there are in this country almost 18,000,000 veterans, of whom almost 14,000,000 served in the second world war. Statistics are conveniently impersonal, and we have thus far miraculously escaped the consequence of our forgetfulness and the neglect to keep our promises. But 18,000,000 men, whatever their differences and variety, share an experience forever unique—service in the armed forces of their country; and they and their families still look to us for the fulfillment of the promise of our undying gratitude which we repeated until it echoed in their ears.

May I, to orient you a bit about what I mean, remind you that in the week in which I write, the Veterans Administration found itself for some days entirely without funds, and in the same week Congress planned a billion-dollar conversion of fifteen warships for more effective service in future wars. Are there veterans here to hear me—mothers, wives, children of veterans? What are your feelings and will you multiply them in your mind's calculation by the millions who perhaps have been made more mindful of the sacrifices that war demands? The veteran is in the world in which we live and if we deny him a decent job, a sound house, adequate medical care, and reward beyond the token of quickly spent bonus payments, we shall one day perhaps learn again that

it has always been the veterans of earlier wars who were in the vanguard of politically repressive movements to the left or to the right.

And if we have apparently succeeded, in our tidy human way, in putting aside that specter, we have succeeded even more completely in forgetting the unemployed, who not so long ago were thick within our land. And, as of May 15, there were again more unemployed in our country than in the first months following the nightmare debacle of 1929. Thus, it seems that the threat of the problem of the unemployed is perhaps greater than we should like to think.[1]

It is never easy to identify one's self with others whose experiences are greatly removed from one's own, especially when the possibility of sharing them seems highly improbable. Perhaps I feel so keenly about the unemployed because I was for so long identified with them as they came into our research interest in such a way as to make calm, scientific objectivity impossible—if, indeed, it is ever possible to be entirely objective about fellow humans, or, for that matter, would be desirable, if it were possible.

It was my privilege to be the psychiatrist in an extended investigation of the unemployed—not the statistics or the economics of business cycles, but men without jobs, some of them unemployed for years. I dare say that no one of us who shared that opportunity will ever forget it or the people who were its interest; even now, six years later, they are vivid in my mind as individuals, and their problems and their anguish is buried deep in my recollection. They were the little people, and it might be worth while to recall a bit about them and to remember that for all its tragedy and bitterness, their story is not without a lesson in courage and hope.

Because, for all the cartoons showing them drunken and the radio comedians' jokes and letters to the editor about the W. P. A. and the bums leaning on their unused shovels, factual studies such as our own showed the unemployed to be rather the ordinary small and pathetic victims of over-

[1] Although a peak of employment has now (August, 1947) happily been reached, I note a curious questioning of it in people and in the press, of all shades of political belief. Warnings abound that this prosperity will not last and our prophesies are frequently rehearsed. Whatever the economic justification for such questioning, it would also seem to reflect unhealthy attitudes.

whelming economic forces and extraordinary only in their averageness. But we learned—as much as one ever can learn from the experiences of others—what it means to be unemployed for years: never to know the luxury of a single extravagance; to watch one's prestige as the man of the house, the wage earner, gradually dissipated; to know the endless searching for nonexistent economies, the often thoughtless and occasionally cruel and always imminent investigation by the authorities, the displacement as head of the family and the loss of authority with one's children, the dread monotony of life without a focus or a goal and without much hope.

A man must be head of the household; if he feels secure in that, he can then share authority and responsibility. He must get up in the morning and go off to work to earn his living and provide for his family; fall into the ranks of fellow workers; nurture hope for a future progress; share a drink or a smoke; come home to be accepted by his family and to find leisure in the interval between work periods.

The unemployed knew none of these things—instead, knew only wasteful idleness and childish contrivances designed to simulate work. I am thinking now of the man who went from the Bronx to the Battery every day, come rain or shine, to look for a job, having a nickel to ride one way and a nickel for the day's food, as he trudged along. Or the man who used the only spoon in the house as his kid's sole digging tool, as well as in its more familiar usage.

I could easily move you, I'm sure, since I have been so moved myself by such true tales. I would rather remind you that not only for these men and women does the threat of unemployment hover, but for the millions of Americans who are the children of the depression and who will never forget that experience or ever escape from the shadow of fear their memories of it occasion. And many of these are veterans who because of their personal experiences feel even more acutely the uneasiness that contemplation of their job situation, now and in the future, induces. They knew unemployment and they will not forget that the country fumbled badly in coming to grips with this scourge of peace. They remember the pregnant women dispossessed from their homes, the farmers thrown off their land, the softness that idleness

produces, the tensions in homes, the cruelty of forever doing without.

Of all the troubles in our troubled world, none is so malignant, so defiant of understanding and remedy, as prejudice, the disease of hate.

Prejudice is a complicated matter with roots deep in the psychopathology of man. It is composed of many facets—social, economic, and emotional—and it is a disease ancient in the history of man. We have just lived through the most terrible and soul-wracking manifestation of hatred the world has ever seen and the end is not yet.

What actually is known of prejudice, beyond its manifestations, is really very little. We know, for instance, that prejudice is learned, that young children lack it entirely. Surely you have all heard the story of the youngster who asked his mother if he could invite a friend to lunch. The mother, aware of the fact that the class was a mixed one, asked the youngster if his proposed guest was a Negro. To which the child truthfully answered, "I don't know. I'll look when I go back to school."

Dr. Eugene Hartley studied the children of the Tennessee mountains, a region rampant with prejudice. He found the young child entirely free of any prejudice and only as the learning process progressed, did prejudice flourish. It is, incidentally, one of the curious paradoxes about prejudice—and the subject is full of them—that the higher the educational level in general, the greater is prejudice.

We know that prejudice is universal, so much so that there are some who would consider it "normal." Thus, in certain villages in the South, anti-Catholic feelings are said to be universal; one found free of such prejudices would be set apart as "queer." And yet in terms of a healthy, emotional adjustment and the capacity to function with sound mental attitudes, it seems most questionable to me if we should ever make peace with the concept of "normal" prejudice. Surely, we all have tastes and likes and dislikes, but aside from factors of intensity and destructiveness, it must always be remembered that prejudice is judgment without experience or fact or knowledge on which to base an estimate; we should not ordinarily expect our tastes to be so irrational. It must be emphasized again and again that racial prejudice *is* irra-

tional—it exists beyond the capacity of reason, evidence, experience, knowledge, or mature consideration to change it. In that sense it may truly be said to be as irrational as the blindest delusion, and as destructive.

One of the characteristics of prejudice is just this capacity to exist without any foundation in personal experience. In fact, it has been repeatedly demonstrated that one of the best antidotes to prejudice is the living experience of sharing.

Last summer I spent a day or two at the summer encampment of the Ethical Culture Society. It was my first personal experience with that sort of interracial, intercultural group, and I wish I could share it with you. Here were a hundred or more youngsters—girls and boys, rich and poor, Negro and Asiatic and white, Jew and Catholic and atheist, city kids and farm kids, the college youngster and the factory worker, all living together and learning by living experience. I remember so vividly the beautiful words of a white girl from the deep South as she expressed her gratitude for this experience. "This is the first time in my life [she was about nineteen] that I have ever spoken to a Negro on the basis of equality and discovered they were just folks like us."

Or the boy from Montana who had never been away from his farm in all his twenty years who asked me the ultimate question, "What shall I tell the kids at home who hate the Jews, but who never really knew one, and anyway the few Jews in our town are good people. What do you say to them in language they can understand to get them away from that?" A question, I should confess, I could not really answer. There are good people busy formulating answers to such questions—educators, sociologists, psychologists, psychiatrists—and one day, we may hope, we will have at least better answers, even though they may still prove unequal to the Herculean task that confronts them.

And so we come to the last of our sources of trouble in our troubled world. It seems best to be humble about it and to pay its enormity the respect of few words.

"On March 3, 1939," Professor Leo Szilard tells us, "Dr. Walter Zinn and I performed a simple experiment at Columbia University. When we saw the neutrons which came off in the fission process of uranium, there was little doubt in my mind that the world was headed for trouble."

How right he was, how dreadfully right! The explosion at Hiroshima did more than destroy thousands and lay waste a city far and wide. For all times it destroyed the illusion that the world could ever again wage war and survive in a civilization comparable to our own. I have spoken with men of maturity and wisdom who have seen Hiroshima. When they tell me its devastation rocked them into unseeing terror, I know the proximity of fear. I have read and heard, as you have, the descriptions and the prophecies, and I am only amazed that our terror is not greater.

Truly we live in a world threatened by disintegration. From the paralyzing fear that wakes us from our sleep to the most impersonal scientific elucidation of nuclear energy, fear is abundant and all about us.

And yet we have our strengths. In the end, as Anna Freud said of the bombed-out British, "we have seen plenty of evil in the world, but one can have only respect and admiration for human beings."

INTEGRATING FACTORS IN PSYCHIATRIC PROCEDURE *

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THE arts of medicine, nursing, psychology, and social work are tools that trained people may use to relieve suffering. When these arts are used in certain ways and with certain objectives in view, it becomes justifiable to refer to them as psychiatric medicine, psychiatric nursing, psychiatric psychology, and psychiatric social work. The adjective "psychiatric" unites them for a common purpose. If their union is to develop and to be profitable in terms of human betterment, we who work with these arts need a clear understanding of what we mean when we use the adjective "psychiatric."

I propose to discuss this term and to indicate how it may serve as an integrating factor between many disciplines.

Any activity deserving the title "psychiatric" must deal with *"living persons, trying to do something about something, somewhere."* Certain arts, such as medicine and nursing, may be focused chiefly on persons. Others, such as psychology, may be primarily concerned with the methods and skills that persons use. Still others, such as social work, may deal more directly with the situations in which people act. Only when an art is concerned with a person, with what he is trying to do, and with where he is trying to do it, does that art begin to merit the description "psychiatric." Such focus represents the first step toward integration.

Concern with the total person and his activities is not, by itself, enough to justify the use of the adjective "psychiatric." Psychiatric activity must be directed toward a specific goal. This goal may be described as the promotion, preservation, or restoration of mental health. In order to be quite clear, this goal should be stated in simple terms.

* Presented at the Second Annual Coördinating Conference of the Western State Psychiatric Institute and Clinic, Pittsburgh, Pennsylvania, April 10, 1947.

Psychiatric activity in any field should aim to make it possible for a patient (1) to live (2) with people (3) happily, (4) productively, and (5) acceptably.

When we combine medical, psychological, and social skills and focus them simultaneously on the goal of mental health, defined in the terms we have just used, we have begun to integrate psychiatric practice. Psychiatry is, however, more than the combined use of several distinct arts aimed at a common goal. No team using medicine, psychology, and social work coöperatively can practice psychiatry unless each of these separate skills is modified by certain fundamental beliefs which constitute the core of psychiatry.

The qualities that add the psychiatric element to medicine, psychology, and social work need to be stated clearly in language that is familiar to the practitioner of each art concerned and yet simple enough to be understood by any non-professional person. These qualities constitute a sort of creed which, if believed in, entitles the believer to attach the prefix "psychiatric" to his professional title. In order to be legitimately labeled a Psychiatric Physician, a Psychiatric Nurse, a Psychiatric Psychologist, or a Psychiatric Social Worker, we must believe:

First, that each individual, as he lives, acquires personal experiences which have, for him, values differing from those that similar experiences may have for any other individual.

Second, that an individual may be unaware of the distorted value that he attaches to his own experiences.

Third, that conflict occurs when an individual's personally distorted values make an adequate solution of current problems impossible.

Fourth, that the resulting conflict may be reflected both in somatic and in social behavior.

If we add this creed to medicine, nursing, psychology, and social work, they all become psychiatric. Belief in the creed does not guarantee therapeutic skill. Therapeutic skill depends on wide knowledge and on properly guided experience. Denial of the creed does, however, remove the psychiatric aspects from any treatment that may be undertaken.

What has been said points clearly to the patterns along which psychiatric treatment seems sure to develop:

First, adequate psychiatric treatment demands such a wide

variety of special skills that no one person can hope to master the entire field. This means that in the future there should be no one person who thinks of himself as "The Psychiatrist," possessed of all the knowledge and skill necessary to treat all patients.

Each of you has met self-satisfied psychiatrists who were horrified by the slightest suggestion that a psychologist, a social worker, or a nurse might dare to treat a patient. Treatment belonged to the physician and to the physician alone. Wherever such people exist, they create bottlenecks. They are unable to treat every patient, but they indignantly refuse to share their rights with any one else. As a result, many patients are not treated. The bigoted idea that psychiatric treatment is the private province of the psychiatric physician must be abandoned.

The second step toward integration of psychiatric practice demands that non-medical professionals be included in the treatment program. Psychiatric psychologists must be called in, not as assistants to the all-wise medical psychiatrist, but as therapists in their own right. When such psychologists accept the psychiatric creed, they must be encouraged to treat patients, but they must carry on their treatment with a full knowledge that their patients have bodies that need medical care and situations that need social guidance.

Psychiatric social workers must be called in to treat patients and must do so with due regard for the patient's body and for his particular skills and handicaps. The question as to whether social workers should treat patients belongs to the past. To-day's question is: "Can this particular social worker treat patients adequately?"

Psychiatric nurses are treating patients. They need to be recognized as therapists and encouraged to do a better job. Ministers can be helped to become therapists if they will add the psychiatric creed to their religious creed.

Hospital attendants do and will continue to treat patients. They need to be taught psychiatry—not the psychiatry of diagnostic labels, but the psychiatry of people trying to do something about what hurts them.

Each worker in the psychiatric team has special skills. The physician has knowledge that the psychologist does not have. The psychologist and the social worker can make contribu-

tions that are beyond the ability of the physician. All of you know that a good hospital attendant can do things that none of you can accomplish. Psychiatry has suffered under The Psychiatrist. It will develop with the assistance of Psychiatric Teams.

For me, integration in psychiatry means the addition of fundamental psychiatric beliefs to every other technique that deals with patients, plus a united effort directed toward helping patients to live with people happily, productively, and acceptably.

VOLUNTEERS IN MENTAL HOSPITALS *

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MANY of our staff have offered suggestions as to a title for this paper. Since the trend toward the use of volunteers in hospitals is becoming more apparent, I think the title I should choose from these suggestions is *The New Look in Volunteers.* As we women took some time in adjusting ourselves to the "new look" in dresses, so I feel it will take time for professional hospital staffs to appreciate fully the capabilities and helpfulness of volunteers and to acquire knowledge of the methods of successfully assigning volunteers to certain types of work in a hospital program, particularly in a neuropsychiatric hospital.

I am, therefore, very glad to discuss a field of work for volunteers in which I am deeply interested and for which I feel there is a vital need. This volunteer aid, besides being of definite help to the professional staff in their work with patients in the hospital, is also one of the best methods of helping educate communities in an understanding of mental illness and of the conditions and needs of mental hospitals, and also in the acceptance of patients on trial visits or on their return to their home communities, since members of these communities, by their interest and work in the hospital, can be correct interpreters of such patients to the community.

There still seems to be some difference of opinion as to the desirability or the value of the service that volunteers can give to a neuropsychiatric hospital. From my close contact during the last six years with this field of volunteer work, I have come to realize that the professional staff need education in the utilization of volunteers to their greatest capacity as much as volunteers need interpretation of the type of work and the type of patient with whom they will

* Presented at the Seventy-fifth Annual Meeting of the National Conference of Social Work, Atlantic City, New Jersey, April 20, 1948.

be in close contact. The Veterans Administration realizes fully the usefulness of volunteers who work either in the hospitals or in the community for the good of the patient. They feel that the volunteer brings the patient closer to the community and, therefore, keeps the community aware of the conditions and activities of the hospital. To quote briefly from an article [1] by Dr. Daniel Blain, recently Chief of the Neuropsychiatry Division, Veterans Administration:

> "With regard to the function of volunteers, we are operating on the principle that a volunteer plays an essential part in the total job of aiding in the recovery of a patient, that he has certain specific functions with regard to doing specific jobs with certain patients, and, in addition, he has general functions which have to do with the background, environment, and other connections of the patient before and after the treatment, and an important relationship to the community at large.
>
> "In general, the volunteer worker parallels the work of the paid employee. I should mention here that those who come in as volunteers without salary and are, therefore, not in a formal employee status, nevertheless are serving for compensation. The compensation in this instance is not financial, but it behooves every one concerned with the volunteer in an administrative and promotional capacity to keep in mind the very important consideration of satisfaction, appreciation, and other forms of compensation which the volunteer worker must have if his work will remain steady and show gradual improvement.
>
> "In general, salaried professional workers are subject to control and selection; certain training is demanded of them; and they have a certain amount of clear-cut responsibility and are subject to certain authority. In addition, they may live in hopes of certain advancement when their work is properly done. It is our belief that all volunteer workers should have the same feeling of responsibility toward their work, should live under the same authority, should be subject to certain types of control and be subjected to a program of selection and training parallel to that of salaried professionals."

To obtain volunteers who really will be good assistants in a hospital program, I would suggest that the professional staff or a selected staff member should first carefully survey the various hospital departments, to ascertain the number of volunteers that could be used to help the scheduled programs or the expansion of these programs. This survey should also include the type of qualification the volunteers should have to assist in each department.

It should be noted that if volunteers with particular ability or interest give their services to a hospital, in most cases they will give regular and dependable service for many years.

[1] In the Voluntary Service Information Bulletin, August 1, 1947.

Our experience has shown that volunteers who are or who have been teachers maintain their interest in coming regularly to the hospital to teach particular subjects to patients. Volunteers versed in music continue to focus their attention on furthering this interest in the hospital. Volunteers interested in athletics, crafts, chess, camera and stamp clubs, seem to maintain their enthusiasm to a much greater degree than volunteers with no particular interest or avocation in their background. The personality of the volunteer also is important. One who is a wholesome, warm, outgoing person seems to encourage patient participation much more readily and gets along well with other volunteers and the hospital staff.

Another important factor in insuring the continued interest of volunteers is keeping them occupied, understanding that they wish to be busy the entire time that they are on duty. We have found that assignments must be planned in advance of the arrival of the volunteers, and that these assignments should be based on real needs of the patients, as well as on the particular abilities of the volunteers. Programs also must be arranged both for daytime and for evening use of volunteers and be planned both on a winter and on a summer basis, since activities differ according to the season of the year. Assignment is not an easy matter, but a most important one. This is particularly true in neuropsychiatric hospitals where there is a constantly growing program and where the great majority of patients are ambulant, permitting the employment of a great variety of activities.

Recruitment periods for new volunteers two or three times a year—one recruitment in October after summer vacations, one in January after the holidays, and one in early May, to plan for the summer months when different activities may be stressed—have been found the most satisfactory way of obtaining the needed number of new volunteers.

The Red Cross has found it necessary to have two professional staff members in most of the Veterans Administration hospitals and even three or four in staff in a few of the large hospitals, in order to maintain a smooth-running Red Cross volunteer program. Among this staff's main duties are ascertaining the needs of the hospital departments, helping chapters to recruit volunteers with particular

aptitudes, and coördinating and planning with hospital departments and Red Cross chapters, volunteer orientation courses, schedules, programs, and assignments. Just as important is their planning for in-service training and—as agreed upon with the various hospital departments—helping in the over-all supervision of Red Cross volunteers. The latter particularly pertains to the recreation program, since nearly every ward has daily programs, and we have found that helpful, continuous supervision, including in-service training, is of the utmost value in stimulating the volunteers' continued interest as well as new program ideas.

I should like to give a brief outline of the steps that we have taken to procure volunteers for Veterans Administration hospitals. These procedures were first undertaken for a Veterans Administration neuropsychiatric hospital about six years ago, and not only are they still successful in helping us obtain new and able volunteers constantly for this hospital, but they are just as successful in procuring volunteers for other neuropsychiatric hospitals.

First, the Red Cross field director at the hospital ascertains the needs of the various Veterans Administration hospital departments. She not only learns the types of service for which volunteers are needed, but also the days of the week, the hours of the day or night, and the particular types of work volunteers will be asked to perform. For example, the occupational-therapy department might wish a volunteer on Mondays from 9–3 to instruct patients in ceramics.

Different age limits are usually found suitable for different types of hospital. Younger volunteers, from twenty-one to forty-five, seem best suited for work in general-medical and neuropsychiatric hospitals; volunteers from twenty-five to fifty, for tuberculosis hospitals.

The field director gets in touch with the Red Cross chapters in the communities that serve her hospital, giving them full details, and the chapters, either through newspaper or radio publicity or, more successfully, through personal acquaintanceship and talks to various community groups, recruit the volunteers.

Chapters hold preliminary interviews in which full infor-

mation on the hospital, the patients, and their needs are given to the applicants.

The prospective volunteers then meet with the Red Cross field director and the particular members of the Veterans Administration hospital staff to whom the volunteers may be assigned, to discuss details of the particular work in which they may participate and the types of patient with whom they would work. At this time, the volunteers and the staff can also ascertain whether the capabilities and interest of the volunteers indicate aptitude for hospital work and for that particular phase of assignment. Application forms filled in by the prospective volunteers show the times that they would be available, their reasons for volunteering and their qualifications for work in any particular hospital, and a number of their main interests, such as games, crafts, music, and so on.

It has been found most helpful to have a psychologist or a psychiatrist at the hospital participate in the selection and the interviewing of prospective volunteers for neuropsychiatric hospitals and neuropsychiatric wards in general-medical hospitals. Simple psychological tests usually are given and although some volunteers may be rejected, the ones who are carefully selected and accepted are the ones who continue to work regularly and successfully and who coöperate wholeheartedly with their fellow volunteers, the hospital staff, and the patients. Those who the hospital feels are not suited for the particular hospital in question are then told by the Red Cross chapter of other services that they could render for Red Cross.

Doctor Florence Powdermaker, of the Neuropsychiatry Division, Department of Medicine and Surgery, Veterans Administration, emphasizes the importance of careful selection of volunteers [1]:

> "Screening of the volunteer is important for the sick both from the standpoint of the patient and the volunteer. The volunteer will only get satisfaction and happiness from his work if he is suited in the first place for work in the hospital and if he is assigned to a job which is congenial and for which he has some gift or training. It is necessary for the patient that the volunteer be screened, so that he will be assured of helpful administrations from the volunteer. Working with the sick is an avocation or a profession for which every one is

[1] In the Voluntary Service Information Bulletin, August 1, 1947.

> not suited, however great the interest may be. It is in part a matter of temperament and personality. Not to be found acceptable is in no way a reflection on the person, but simply means his personality and talents suit him for a different kind of work. It aims to keep the round peg from a square hole. If done in this spirit, screening is not a problem and one can be assured of the coöperation of both the individuals and the organization."

All accepted volunteers then attend an orientation course of about fifteen hours in length. This course consists of a Red Cross chapter lecture, after which the Red Cross hospital staff and representatives of the various hospital departments participate in conducting a series of lectures, panel discussions, and tours of the hospital. A short examination follows and then a probation period, during which it can be ascertained where the volunteers would best fit into the hospital program and an evaluation can be made of their interest and coöperation.

Volunteers are asked to promise to serve a minimum of from fifty to one hundred hours a year. In-service training is scheduled regularly, so that the volunteers are always aware of changes in or broadening of the hospital program; this orientation is planned by Red Cross staff and the volunteers. Hospital staff members often participate, giving detailed information as to their own departments.

We are trying not only to encourage group recreation, such as parties and dances, but to stress as much individualized attention and individualized recreation as possible. This not only holds the interest of the volunteers, but seems to be beneficial and pleasing to the patients.

A well-planned recreation program continues on a daily basis for all wards, even the acute service, and we try to stimulate volunteers to encourage patient participation to the highest degree, particularly on an individual basis. In other words, the volunteers try to start responsive patients playing games, and then focus their attention on the patients who seem to withdraw and not to wish to participate.

A great part of in-service training, therefore, is focused on games of various kinds. Field directors and volunteers always are looking for new games that will interest the patients and that could be used in the recreation program. Besides individual recreation, volunteers sponsor dancing classes, musicals, community singing, plays with patient

participation, and various group activities, such as chess and stamp clubs.

Volunteers are of great service to many departments in the hospital in addition to the recreation department. Selected as much as possible on the basis of their knowledge, they are assigned to the library, and besides helping in the regular routine—even covering the library at times in the absence of the librarian—they also read to patients and hold discussion sessions on various subjects. Again, there has to be a careful selection of readers or discussion leaders, so as to hold the attention of a patient or a group of patients.

Volunteers show enthusiasm in the athletic program and participate in activities such as golf, tennis, croquet, badminton, softball, swimming, archery, fishing, and skiing.

There are two types of craft program in Veterans Administration hospitals—occupational therapy and manual-arts therapy. Occupational therapy differs from manual-arts therapy in that it offers medically prescribed activities, determined by the emotional and physical needs of each patient for purely therapeutic purposes. The manual-arts-therapy program is directed toward the exploration, direction, and preparation of the individual for vocational training and placement in an industrial or a trade activity.

Volunteer recruits for these two departments are interviewed not only at the community level by the Red Cross chapter, but also by a representative of a museum or a craft school, who makes a professional evaluation of the volunteers' qualifications and knowledge of particular crafts. Often the chapters will hold craft courses to train additional volunteers. After acceptance by the hospital and the orientation course, these volunteers work under the direct supervision of the Veterans Administration occupational-therapy and manual-arts-therapy departments.

Also, since many volunteers are used in the occupational-therapy department, this department in many hospitals holds series of lectures and instruction courses as in-service training, to broaden the knowledge of their skilled volunteers. Volunteers versed in ceramics, woodworking, metal and jewelry, painting, plastics, leather, and weaving seem to be the ones most needed by the occupational-therapy department.

There is an extremely wide range of craft work needed

in a large neuropsychiatric hospital, as not only the degree of skill of the patients or their potential ability, but their mental state must be taken into consideration. The arts-and-skills volunteer working with mental patients must have, not only an excellent knowledge of her particular craft, but a stable and well-balanced personality. The work requires great patience and understanding, and sympathetic knowledge of the patient's illness. The work with some of the more regressed patients is on the level of kindergarten crafts. These patients will have a very short interest span. With such cases, volunteers have found that adding music and gardening projects to the craft program has been most valuable in keeping the patients' interest at a high level.

Volunteers work in the occupational-therapy clinics and also directly on the wards, not only with ambulant, but with infirm and bed-ridden patients. Here the workers must do a great deal of preparation work, as many of the men are not physically able to handle some aspects of the work. Their program must be adapted to the special needs of wheel-chair patients and of those with particular disabilities.

A report from one neuropsychiatric hospital, in which 179 patients are enrolled for courses in vocational subjects, states:

> "Besides assisting the manual-arts-therapy department in teaching simple and artistic crafts, volunteers are used in this program also to assist in carpentry, cabinet making, upholstery, textiles, printing, machine shop, sheet metal, photography, electricity, radio, art leather, shoe and luggage repair, graphic arts—including blue-print reading and mechanical drawing—precision casting, and art metal work.
>
> "In the graphic arts and mechanical-drawing shop, volunteers are now teaching blue-print reading, mechanical drawing, sign painting, lettering, and design. In this shop, as in many others, patients who are newly assigned by doctors' prescription may still be in some state of mental confusion. It is with these men that volunteer workers can be particularly helpful. These patients may require almost constant individual instruction for some time. Much as the instructors might wish to give a great deal of personal attention to these men, it is impossible, with the number of patients in the class, to give all the individual instruction desired. But, with sufficient volunteer aid, much personal help can be given to the patient who is a bit slow to learn as well as to the man who may advance quickly to a higher degree of skill than his fellow students.
>
> "Volunteers who have been experts in dressmaking are now readapting their skills to fit the more commercial methods used in the textile shop. With a few lessons of instruction in operating power machines, rather than their home models, and cutting dozens of garments from

patterns at one time instead of the usual single dress, they prove to be of great help in this commercial sewing shop.

"In addition to these volunteers who serve regularly, specialists who can come to lecture on the job opportunities and latest methods in various trades are being located through the various chapters to talk to the patients. One of the local chapters stimulated the interest of the head of the graduate school of a local college of engineering, who visits the hospital regularly. Through the interest and contacts of just this one volunteer, arrangements are being made for teachers from vocational schools and local business experts to give lectures and to help advise the patients in their future plans for study and job opportunities, after their discharge from the hospital.

"Many donated items are being collected for work in these shops. Radios in any condition are needed for use in teaching radio repair, and many dozens of these, as well as small motors and many other items, have been collected and donated to this program.

"The teamwork between the paid workers and the volunteer enables the hospital to give far more concentrated attention to the patients. Occasionally, in neuropsychiatric hospitals, there will be a patient who is more antagonistic toward paid staff members, feeling that they conspire against him. A patient of this type may be willing to trust the volunteer and respond to her suggestions (relayed from the professional staff) until he has regained confidence in the sincerity of the desires of every one to help him recover.

"The volunteers themselves very often become so interested in their work that they continue to study and attend craft classes in their communities."

Another department to which volunteers are assigned is educational therapy. Patients may study any course in which they are interested and the Red Cross has recruited teachers for most of the requested subjects.

To quote from another report from a Veterans Administration neuropsychiatric hospital:

"Volunteers have become of great value in developing rapport with patients, stimulating interest in the retraining area, and in general reducing a patient's tension and anxiety by merely being an objective and understanding audience to his problems. They guide and instruct individual patients in typewriting, shorthand, bookkeeping, business subjects, English, social science, and mathematics. The academic level runs from basic educational needs for illiterate patients through to college-level work. Many volunteers are equipped with special interest and skills such as journalism, design, and scientific backgrounds. Every opportunity is seized to enable a volunteer to employ this specialty in the program. For example, the specialty in journalism is promoting patient contributions for the local hospital bi-weekly publication.

"In addition to being a valuable supplement to the regular instructor staff, the volunteers have contributed a wholesome atmosphere by their daily presence in the classrooms. Patients respect the 'Gray Lady' uniform, they enjoy the daily association with people from 'outside.' The increased individual supervision results in a corresponding stimulus

> of a patient's feeling of being an individual—a goal in psychotherapy. This is evident by the patients' increased attention to their personal appearance, the spontaneous display of courtesy by some patients, and by the gradual responsiveness of heretofore seclusive individuals."

We have found that it is not wise to recruit volunteers who are interested only in teaching, as many patients in a neuropsychiatric hospital will not be able to follow a daily or even a weekly teaching routine. Therefore, it is well to select a volunteer who has a teaching background, but who will be willing to work in other phases of the hospital program if patients to whom she could be assigned are not available the day she arrives. We have also been able to use units of students from colleges who come regularly to some of the hospitals to study with the patients or to teach them.

Volunteers are assigned to the Veterans Administration nursing department to help feed patients, fold surgical dressings, and mend and sew for the patients.

Other volunteers in the Red Cross chapters serving the hospital indirectly aid the nursing department by making articles for the patients, such as sweaters, socks, pajamas, covers for crutch pads and hot-water-bottles, cushions and day-room curtains, and so on.

Other Red Cross volunteers are members of the canteen service and after receiving a required Red Cross canteen course, serve at teas and picnics, and so on.

Another volunteer service available is that of clerical work for the various hospital departments. Some of the departments in which these volunteers assist in Veterans Administration hospitals are social service, chaplains', special services, recreation, athletics, library, various departments under physical-medicine rehabilitation, dietetics, and clinical records. They also help edit and set up the hospital newspaper or magazine.

In many of the hospitals the medical service asks that volunteers be directly assigned to individual psychiatrists for special types of work with certain patients. Gray Ladies taking active rôles often participate in psycho-drama and are active in planned group-psychotherapy parties which are closely supervised by the psychiatrist in charge. Under the supervision of a psychiatrist, they help in the post-operative

education of leukotomy patients on a daily basis. Reports from psychiatrists and volunteers on this particular type of work are most enthusiastic.

Volunteers work also on the acute intensive-treatment service and assist in the electric-shock and insulin-therapy programs. They play music, simple games, converse with patients before their shock treatment, and assist in the feeding after shock treatment. One psychiatrist writes:

> "In the insulin service, patients emerging from coma frequently pass through phases of early life. In these, one man needs a smiling face; another a soothing maternal voice and hand. In all, the reëstablishment of contact with reality is made easier, and a wholesome return is favored, by the presence of Gray Ladies. Another part they play here is in the selection of suitable record music to provide an easy and emotionally satisfying awakening.
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> "In the electro-therapy service, too, patients awaken from a period of unconsciousness, through helplessness to full awareness. Again, the Gray Ladies, with music, with refreshments, with their kindness and interest, provide a setting that favors the wholesome reintegration of a personality.
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> "In the psycho-surgery program, which is rather intensive at this hospital, the interest shown by the ladies who have devoted themselves to this program has resulted in what might well turn out to be a major contribution. With a thumb-nail sketch of the patient's personality and the problem presented, these ladies have developed an educational program, which begins with elementary speech mechanisms, advances by degrees through the uses of vocabulary, symbolic constructions, up to the ways of the outside world in everyday life, correct manners, and practices in ethical reasoning. As we know how far from accepted customs the patient is who has been approved for leukotomy, and how great is his need of reëducation, we look upon the program of the Gray Ladies with warmest approval."[1]

Volunteers also have successfully assisted the social-service department in their work with patients. The following list of specific kinds of duty performed by Red Cross volunteers in conjunction with and under the direct supervision of social-service workers is reported by one of the hospitals:

> "They make initial contact with new patients to inform them of the general functions and availability of social service; help patients fill out forms for clothing requests, insurance blanks, application blanks, etc.; help patients write letters to relatives in matters pertaining to social service; perform contact work on all request items such as wheel chairs, eye glasses, etc., as a follow-up on the original contact; and under the direction of social-service workers, contact patients on the ward who need an opportunity of talking with some

[1] Quoted from a letter from Dr. W. J. Turner, Veterans Administration Hospital, Northport, New York.

one when they are especially low and lonely with a view toward referral to the social worker of any case-work problem. This could be termed 'companion service.' "

We have seemed to focus most on the work of women in this paper. However, many men volunteers have been recruited to participate in programs in neuropsychiatric hospitals. In one neuropsychiatric hospital, over one hundred men are now serving, and besides working in the occupational-therapy, the manual-arts-therapy, and the educational-therapy departments, men volunteers, with women volunteers, are actively participating in sports activities with the patients at the hospitals and very often in the communities. Men and women volunteers are active in various patient clubs, such as stamp, chess, book clubs, and so on. They also plan forum discussion groups and theatrical plays with volunteer and patient participation under the supervision of a hospital staff member.

Besides the volunteers who serve on a regular basis, there are those who occasionally act as hosts and hostesses for parties and dances and who entertain on the wards or in the auditorium. Many dances could not be held without the attendance of girls from the community. These volunteers who serve only on an occasional basis receive a brief orientation by the Red Cross hospital staff on hospital policies and the neuropsychiatric patient. It has not seemed necessary for these volunteers to participate in the entire screening and training process discussed above since they are at the hospital on very few occasions and are under constant supervision.

The number of volunteers required to fulfill the needs grows constantly as the various programs expand. At one hospital, we have over 400 volunteers per month, and we are recruiting more. All these are capable, trained volunteers who give regular service, coming from distances of from five to fifty miles away.

One of the main contributions volunteers make is that of helping the patient feel himself one of a community. Community participation is needed to foster a patient's interest in community activities. The Red Cross motor service transports patients from the hospital on sightseeing trips, to picnics, baseball and football games, plays, and other forms

of activity, such as bowling, skiing, tennis, and dancing classes in the community. Visits to industries have resulted in many patients' acquiring jobs in the community. Also, many patients attend meetings of the Rotary, Lions Clubs, and other community organizations, and have entered into civic contests such as the "model-home" contest. Quiz programs on the radio, with joint patient and community participation, seem to be enjoyed both by community members and by patients.

Many organizations, as well as schools, colleges, and other educational institutions, also are of great service in contributing material supplies, since many people cannot give time to work at the hospitals, but wish to show their interest in the patients.

To summarize briefly, I would say that for in-hospital work, in order to utilize fully and successfully volunteers who will be of real aid to the patient and the hospital staff and who will enjoy continuous participation in their work, there must be careful selection and training and a well-planned coördinated program which must be kept on a continuing, well-organized, and growing basis.

Also, through the volunteers' close relationship with patients in neuropsychiatric hospitals, a better understanding of this particular type of disability is diffused throughout the community. This personal interpretation by a hospital volunteer who is a member of the community is, I feel, one of the best ways to disseminate knowledge of mental illness to the community.

PLANNED PARENTHOOD AND MENTAL HYGIENE*

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NONE of you is unfamiliar with the medical and social reasons for birth control. The struggle that women have made to win the right of self-determination in the matter of their child-bearing function was based largely on their bitter experience with, or their awareness of, illness and poverty. It is of much greater significance, however, that it was precisely those women who were not personally concerned with ill health or malnourished children who enlisted in this cause. Their own profound maternal impulses impelled them to the furtherance of a purpose that was looked upon in many quarters as anti-maternal and anti-biological, if not worse. Many of these women saw not merely the need for safeguarding the physical health of mothers or the economic security of families. Intuitively, they grasped the fact that many a poor working couple can afford a family while many a wealthy pair cannot.

To-day, on the basis of our scientifically acquired knowledge of human nature, it is possible to verify the validity of this seemingly paradoxical notion. For the fact is that parenthood is not merely a matter of physical or of financial capacity. These factors must of course be given due weight, but it is the emotional solvency of the potential parents that is of first importance to the offspring.

Let us consider for a moment the name of the organization whose hospitality we are enjoying this evening—the Planned Parenthood Association. It was not so long ago that such an organization might have been known as the Birth Control League, or the Society for the Dissemination of Contraceptive Advice, or as the Association for the Rights of Women. There was something negative, something "anti" about all this. "Planned Parenthood" is a positively toned phrase. How-

* Presented at a meeting of the Planned Parenthood Association, Chicago, February 10, 1947.

ever, despite the fact that an advertising copywriter would prefer it as having greater sales appeal and being less likely to rouse negative feeling, there is a much more profound and valid reason for its use. On the planning of parenthood rests the very fate of our civilization.

We have just ended the most destructive war the world has ever known. And it is possible that we cannot avoid the next one—not because of insoluble economic and political problems, but because the generation that may fail to solve these problems has already been born. That generation has come from parents who were emotionally unready for parenthood.

Let me quote from an article written by Dr. Karl Menninger several years ago.[1] Dr. Menninger said:

> "The reason that contraceptive knowledge and counsel seem to the psychiatrist to be essential is based not upon considerations of the welfare of the adult, but upon the considerations of the welfare of the child. Nothing is more tragic, more fateful in its ultimate consequences, than the realization by a child that he was unwanted. Where one child reacts to this in later life with an acute mental illness, dozens of children react to it in more subtle ways by developing self-protective barriers against the inner perception of the feeling of being unwanted. This may show itself in a determined campaign or in a provocative program of attracting attention by offensive behavior and even criminal acts. Still more seriously it may show itself as a constant fear of other people or as a bitter prejudice against individuals or groups through deep-seated, easily evoked hatred for them. The rage of the Southern poor white against the Negro suspected of some dereliction is referrable to the hate he feels inwardly at having been himself, like the Negro, unwanted. The same is perhaps true in the case of Germans and Jews and in many other situations which give opportunity for expression of hatred in the denial of the feeling of being rejected. The importance of this factor in the psychology of war is even greater, in my opinion, than the economic factor arising from the increase of population. This is why I say that from the purely scientific point of view, planned parenthood is an essential element in any program for increased mental health and for human peace and happiness. The unwanted child becomes the undesirable citizen, the willing cannon fodder for wars of hate and prejudice."

What do we understand emotional readiness for parenthood to be? Most important is the fact that the begetting of the child is the climax of the development of the father as a man and of the mother as a woman. The sexual union is not simply the physical prerequisite. We are already practicing artificial human insemination and the eggs of certain lower

[1] "Psychiatric Aspects of Contraception," by Karl Menninger. *Bulletin of the Menninger Clinic*, vol. 7, pp. 36–40, January, 1943.

forms of life have been stimulated to develop effectively by physical and chemical means. The point is that the sexual union, if it is to mean effective parenthood, must represent the emotional maturation of the partners as individuals and as an integrated pair.

This point can be best illustrated by a paradox. It is well known that a second marriage may be successful despite the fact that the preceding one had failed. In such instances, the first marriage may have represented some essential incompatibility of two relatively mature persons; or it may have been that the first marriage served the particular person in question as an opportunity for completing his or her emotional development. We might say that the first marriage was a training period for the second one.

The emotional maturation of the potential father implies his emancipation from maternal ties and paternal control without hostility. It further implies the development of personal responsibility and initiative and the capacity to carry these into his interpersonal and sexual life with strength, but also with regard and tenderness. It implies, finally, that while he may want and accept his partner as a source of the maternal care that he has left behind him, his offspring will none the less represent to him his whole-hearted gift to the partner and not an intruding rival.

The emotional maturation of the potential mother implies that she has overcome the fears of her biological lack of initiative and control, her fears of being the one who is acted upon, her fears of being passively and helplessly dependent upon another person's regard and tenderness. It implies that she has come into harmony with her child-bearing function as a creative act rather than as an unworthy means to an end that is not her own.

In an emotionally mature union we should expect to find not the grinding of old axes on new stones—not the reliving of old demands, old self-assertions, old envies and rivalries, and with these old hostilities and anxieties. A mature union brings the realization of old love in a new relationship. In a mature union we should expect to find interdependence and mutual respect which is more than skin deep. Children of such a union would really have a chance to develop into human beings whose decency also would be more than skin deep.

This is all very well. But you may rightfully ask: What has this to do with planned parenthood, and particularly planned parenthood as a triple-A priority of our time? It has this to do with it: Planned parenthood cannot be looked upon in any other way than as one of the aspects of a total program of mental and social hygiene. As Dr. Menninger has said: "The children of the future do not 'belong' to their parents alone: they are the concern of every one of us; they are literally the hope of the world." Practically speaking, this sums itself up in this way: It is better to have divorces without children than unhappy marriages or divorces with them; it is better to have childless marriages that are stable and more or less happy and socially effective than unhappy marriages with them; it is better to have fewer children, who come relatively late in marriage after the partners have had a chance to mature, either through their own experience and development, or with appropriate assistance, than to have many emotionally disturbed children. Planned parenthood really must be looked upon as planned childhood.

This can bring us to only one conclusion: Contraceptive techniques are only one of the means to our end. Clinics for planned parenthood cannot simply dispense advice as to how not to have children. Planned parenthood involves a comprehensive approach to the emotional problems of the whole marriage structure; it involves the concomitant use of wise counsel, technical psychiatric skill, and medical techniques.

We need not be fearful that we will thus simply be fostering selfishness and indolence in relationships of convenience. The positive psychological impulses of men, and even more of women, are of sufficient strength in the direction of parenthood to prevent false arguments and purposes from standing in the way. People are capable of being not simply fathers and mothers, but good parents as well. We need only to help them deal with the emotional obstacles that are in the way. We cannot afford to forget that our survival, together with the best in our several cultures, depends not simply on size of population, but on children of emotionally healthy parents.

NAIL BITING AND MENTAL HEALTH

A SURVEY OF THE LITERATURE

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NAIL biting is a problem that has received but scant attention in professional circles. Except for a few early studies in connection with child guidance and some more recent studies carried on in the armed forces, nail biting has been the subject of only cursory investigation.

In the present paper, the material that has been published concerning the incidence and the etiology of nail biting is reviewed and an attempt is made to integrate these findings, in order that the various factors relating to the incidence, the etiology, and the therapy of nail biting may be more clearly delineated. The present review and integration of experimental findings was also considered a necessary first step, preliminary to the further investigation of certain factors relating to nail biting by the present authors.

INCIDENCE OF NAIL BITING

Incidence Among Certain General Groups.—The most complete study of nail biting available in the literature is more than fifteen years old. In 1931, Wechsler[1] observed over three thousand school children in all grades and found the incidences presented in Table I. From this material it will be seen that the greatest incidence of nail biting among the subjects occurred in the early adolescent period, the years twelve, thirteen, and fourteen being especially significant. The peak incidence occurred at the age of thirteen in both sexes—43.6 per cent among males and 44.4 per cent among females.

[1] See "The Incidence and Significance of Fingernail Biting in Children," by D. Wechsler. *Psychoanalytic Review*, Vol. 18, pp. 201–9, April, 1931.

TABLE I.—INCIDENCE OF NAIL BITING AMONG 3,000 SCHOOL CHILDREN *

Age	*Percentage of nail biters in general male group*	*Percentage of nail biters in general female group*
5.....	27.1	20.6
6.....	29.4	31.0
7.....	35.9	30.9
8.....	35.7	39.9
9.....	38.5	25.6
10.....	33.9	33.7
11.....	33.7	32.9
12.....	35.0	43.7
13.....	43.6	44.4
14.....	42.0	34.3
15.....	32.4	31.1
16.....	27.9	23.9
17.....	19.0	15.9

* As found by Wechsler.

Pennington,[1] in a more recent study of white naval recruits, added to the information concerning the incidence of nail biting. Table II presents the incidence rates in this group, between the ages of seventeen and twenty-nine. Pennington found from his study that the over-all frequency of the nail-biting habit was approximately 21.5 per cent. He concluded: "This percentage suggests that roughly one white male in five, between the ages of seventeen and thirty-seven, bites his nails." He noted the decremental trend apparent in his data, and pointed out that with increasing age, fewer and fewer men were addicted to nail biting. At the ages of sixteen, seventeen, and eighteen, approximately one male out of four revealed this habit. At thirty, however, the ratio dropped to one in nine, and at thirty-seven to only one in twelve.

The above quoted incidence tends to be confirmed by a later study of naval inductees in which Pennington and Mearin[2] found the general incidence to be about 23 per cent. From these studies, and from the one made by the authors,[3]

[1] See "The Incidence of Nail Biting Among Adults," by L. A. Pennington. *American Journal of Psychiatry*, Vol. 102, pp. 241–44, September, 1945.

[2] See "The Frequency and Significance of a Movement Mannerism for the Military Psychiatrist," by L. A. Pennington and R. J. Mearin. *American Journal of Psychiatry*, vol. 100, pp. 628–32, March, 1944.

[3] In a study to be published shortly in the *Journal of Abnormal and Social Psychology*, the authors found that approximately one out of three college males and one out of five college females bit their nails.

TABLE 11.—INCIDENCE OF NAIL BITING IN GROUP OF WHITE NAVAL RECRUITS *

Age	*Total number*	*Number of nail biters*	*Percentage of nail biters*
17.....	938	260	27.7
18.....	1,321	319	24.1
19.....	527	94	17.8
20.....	260	54	20.8
21.....	143	19	13.2
22.....	143	23	16.0
23.....	105	16	15.2
24.....	96	10	10.4
25.....	106	16	15.1
26.....	121	17	14.0
27.....	115	14	12.2
28.....	124	12	9.6
29.....	111	13	11.7

* As found by Pennington.

it seems difficult to agree with Bott and Blatz,[1] who concluded that "habits such as thumb sucking, nail biting, . . . seldom persist beyond the fifth or sixth year unless the trouble has been aggravated by the mother's attitude." Further substantiation for this opinion comes both from Viets[2] and from Olson,[3] who have shown considerable incidences at later ages. Olson stated that "age differences in the manifestation of oral habits are unimportant." This conclusion, however, would seem to undervalue the age factor, since the habit has been shown in several studies to be of decreasing importance with age.

The decreasing incidence of nail biting with age, noted by both Wechsler and Pennington, was further substantiated by Shahovitch[4] in an investigation of children in the Los Angeles public-school system. Shahovitch found that the number of nail-biting children increased up until about the sixth grade, but that exceedingly few children acquired the habit after this period—*e.g.*, the age of twelve. However, she pointed out that children may later renew a habit of their early years

[1] See *Parents and the Pre-school Child*, by H. Bolt and W. Blatz. New York: W. Morrow, 1929.

[2] See "An Inquiry into the Significance of Nail Biting," by Louise E. Viets. *Smith College Studies in Social Work*, vol. 2, pp. 128–45, December, 1931.

[3] See *The Measurement of Nervous Habits in Normal Children*, by W. Olson. Minneapolis: University of Minnesota Press, 1929.

[4] See "Don't Scold the Nail Biter," by Gladys P. Shahovitch. *Hygeia*, vol. 23, pp. 302–4, April, 1945.

which had been broken for a time and forgotten, but that the basic pattern had been previously established in such cases and could not be considered as beginning at the later age.

Utilizing a different approach, Billig [1] investigated the incidence of nail biting among children from fourteen to sixteen years of age for the consecutive years 1940 to 1945. His findings are similar to those of previously mentioned investigators and are presented in Table III. In the evaluation of his data, Billig noted that there was considerable consistency of incidence, which he attributed to the consistency

TABLE III.—PERCENTAGE DISTRIBUTION OF FORMER AND PRESENT NAIL BITERS AND NON-NAIL BITERS AT AGES FOURTEEN TO SIXTEEN *

Year	*Present nail biters*	*Former nail biters*	*Non-nail biters*
1940.....	27.9	37.4	34.7
1941.....	29.3	38.0	32.7
1942.....	27.8	37.2	35.0
1943.....	27.3	36.7	36.0
1944.....	28.2	41.8	30.0
1945.....	27.1	40.0	32.9

* Adapted from Billig.

of the individuals within the samples themselves. This is puzzling in view of the fact that the samples never used the identical subjects more than once, and hence individual consistency would appear to be a rather meaningless concept. Billig noted no significant change in the incidence of nail biting during the war years.

From the above findings, it may be concluded that the problem of nail biting is not a rare one, and that the incidence is much greater than is generally realized. It seems logical, also, to study further the possible importance of a habit that is found among almost one-fourth of the young men eligible for military service.

Incidence of Nail Biting Among Certain Special Groups.—The incidence of nail biting has been studied among a number of selected groups. Goldfarb,[2] for example, noted that more than twice as many infants reared in institutions, as com-

[1] See "The Consistency of Fingernail Biting," by A. L. Billig. *Proceedings of the Pennsylvania Academy of Science*, vol. 20, pp. 39–43, 1946.

[2] See "Infant Rearing and Problem Behavior," by W. Goldfarb. *American Journal of Orthopsychiatry*, vol. 13, pp. 249–65, April, 1943.

pared with those reared in foster homes, had habits of nail biting, nose picking, or lip sucking. This difference was notable at all ages, but was most evident at the eight-and-one-half-year level.

In a survey of stuttering children, Despert [1] found oral habits common. Thumb and finger sucking, common among the younger children, were said to be replaced by nail biting at later ages. Of these speech-defective children, almost one-half "showed evidence of severe nail biting, and nearly all were observed habitually to bite their nails."

Among delinquents, however, Michaels [2] did not find significantly more nail biting than among appropriate control subjects. Comparing one hundred and five delinquents and their sibling controls, he found that 11.4 per cent of the delinquents and 6.7 per cent of the non-delinquents bit their nails. This did not constitute a statistically significant difference. Shahovitch,[3] on the other hand, concluded from her work in the field that the majority of delinquents were nail biters.

Nail biting among neuropsychiatric rejectees in the second world war has been studied by Rottersman.[4] In his study he found that from 35 to 40 per cent of those rejected bit their nails, as compared with about 25 per cent of the accepted selectees. He found that over 90 per cent of the persons who had a history, past or present, of finger-nail biting were accepted into the armed forces. However, the rejection rate for those who no longer bit their nails was 16 per cent; and for those who still did, 33 per cent.

It may be noted in passing that both in the case of the selective-service rejectees and in that of the delinquents, it appears that nail biting *per se* cannot be used as a diagnostic tool, although it may enter significantly into the adjustment of the individual.

Considerable evidence has come out of World War II con-

[1] See "Psychosomatic Study of Fifty Stuttering Children." (Round Table.) "Social, Physical and Psychiatric Findings," by J. Louise Despert. *American Journal of Orthopsychiatry*, vol. 16, pp. 100–113, January, 1946.

[2] "Psychological Interpretation of Delinquency," by J. J. Michaels. *American Journal of Orthopsychiatry*, vol. 10, pp. 501–9, July, 1940.

[3] *Op. cit.*

[4] See "The Selectee and His Complaints," by W. Rottersman. *American Journal of Psychiatry*, vol. 103, pp. 79–86, July, 1946.

cerning nail biting among men in the actual war situation. Grinker [1] and associates studied this factor and many others in relation to the predisposition to operational fatigue in enlisted flying personnel. They found that among the men diagnosed as having severe operational fatigue, 56 per cent were nail biters. Among those diagnosed as having only mild operational fatigue, 43 per cent were nail biters. Among the control group, non-operational fatigue subjects, the incidence was only 26 per cent. Summarizing the findings, they considered "the greater frequency of overt neuroses and neurotic trends, such as sleep disturbances, enuresis, nail biting, stammering, and frequent accidents," as part of the syndrome, indicating greater predisposition to operational fatigue. It was not explained whether these nail-biting men had been nail biters prior to their army service or not.

In order to determine the military significance of the habit, Hill [2] made a thorough study of nail biting among men who had experienced foreign and combat duty. The aim of this study was to see whether nail biting could be used to select those whose personalities were useful for military combat purposes. As subjects, he used naval and marine personnel who had been evacuated to this country because of nervous conditions. He found that 45 per cent of two hundred and twenty-three routine admissions were nail biters.

More than half of the one hundred nail biters had bitten their nails periodically or continuously since their earliest recollections. The remainder began the habit in association with combat, or gave it up before their present illness. A comparative study was made of those who were not in the hospital for nervousness and who were separated from military service on the point system. Of these, only 6 per cent were nail biters by the same criteria, half of whom had bitten their nails ever since they could remember.

In no study recorded have the present authors found it stated that nail biting is an adequate basis for diagnosing

[1] See "A Study of Psychological Predisposition to the Development of Operational Fatigue: II. In Enlisted Flying Personnel," by R. R. Grinker, B. Willerman, A. D. Bradley, and A. Fastovsky. *American Journal of Orthopsychiatry*, vol. 16, pp. 207–14, April, 1946.

[2] See "Nail Biting: Incidence, Allied Personality Traits and Military Significance," by J. M. Hill. *American Journal of Psychiatry*, vol. 103, pp. 185–87, September, 1946.

either manifest or latent maladjustment. The fact, however, that it is often found disproportionately among the less well-adjusted members of society is not disputed.

ETIOLOGY

Psychoanalytic Contributions to Etiology.—One of Freud's stages of psychosexual development is the period of infantile sexuality. A subdivision of this is the oral phase, in which the child seeks pleasure autoerotically, fixating his attention about the mouth. Among the oral activities often mentioned are sucking and biting. It is in this frame of reference that nail biting has been often interpreted as a response to or a fixation at the infantile oral stage of development.

A relationship between the habit of nail biting, the Œdipus situation, and unconscious masturbatory activity has been postulated by Wechsler.[1] He assumed that failure to resolve the Œdipus situation resulted in regression to an infantile level of adjustment at which oral habits were more appropriate. In his study mentioned above, Wechsler found a direct relationship between nail biting and the onset of puberty, which he interpreted as due to the revival of guilt feelings at this time. He found that the maximal incidence of the habit occurred at age twelve among girls and at age fourteen among boys. Explaining this, he stated:

> ". . . from the point of view of psychoanalysis, finger-nail biting is a manifestation or a symptom of one of two regressive proclivities. In the first place, it may serve as a means of oral erotic gratification, and thus be looked upon as a continuation of the infantile thumb-sucking habit. This libidinal significance of the act is perhaps most clearly indicated by the type of situation which calls forth the activity in the adult who is not an habitual nail biter. These situations are almost invariably instances of stress, as when the individual is under mental strain, worried. . . . Taking the finger into the mouth, like thumb sucking, serves as a pacifier, being a reversion to that archaic activity which was the supreme assuager of all distress, the mother's nipple. But the more common significance of the habit, and the one that explains the biting of the nail as well as the introduction of the finger into the mouth, is that it serves as an onanistic equivalent. Finger-nail biting, as psychoanalysis has shown to be the case of most tics, is nothing but a particular form of unconscious masturbation activity. Its indulgence becomes possible, as in the case of all neurotic symptomatology, by carrying with it the punishment which the tabooed act calls for. The punishment for the playing with (using) the penis is of course

[1] *Op. cit.*

> castration. The symbolism involved is obvious to psychoanalysts: I defy the prohibition to manipulate my penis (taking finger in mouth) and accordingly must suffer the penalty of having it cut off (biting the nail off). Continued fingernail biting is thus a symptom of an incompletely resolved Œdipus situation."

Relating this theoretical orientation to his observational study of nail-biting school children, Wechsler further stated:

> ". . . the correspondence between the psychosexual phases and the ages at which the different intensities of the finger-nail biting occur, becomes almost self-explanatory. Before the age of three, there is no finger-nail biting. That is inevitably so, for the child is still in the pre-phallic stage of psychosexual development. The nipple or its equivalent has continued as its source of oral gratification, and the Œdipus situation has not as yet come to trouble its libidinal strivings. There is as yet no occasion for substitute formations. Age three to five: Beginning of nail-biting activity with gradual increase. This is again what we should expect. For it is at this age period at which the child is confronted by the Œdipus situation on the one hand and the beginnings of directed prohibitions on the part of the parents against manifestations of genital activity, an activity which is precisely at this time at its height. The genital activity is of course a reaction to the Œdipus conflict, but the onanism which it represents, no less than the incest strivings, are taboo. It must be similarly given up. The beginning of the finger-nail biting represents a beginning at vicarious attempts at genital and onanistic activity."

Wechsler drew a further temporal parallel between the habit and psychosexual development. He found an increase in nail biting at the beginning of the latency period at about six years, an unchanging level of incidence until puberty, and then a sharp rise when the Œdipus situation was said to be revived. When the individual acquired adult sexuality, "we should accordingly expect a rapid fall in the incidence of finger-nail biting and that is what is actually observed."

From these formulations, Wechsler concluded that what had formerly been looked upon as a habit was more nearly a symptom, and—at least in its milder forms—not pathological. Since he viewed nail biting as a symptom of an unresolved Œdipus conflict, Wechsler felt that "all efforts at reducing it, based on the psychology of habit formation, must be doomed to failure, and anybody who has experience in the application of such habit-breaking procedures as applications of aloes and taping fingers knows how useless they are."

Wechsler's conclusions are of great interest relative to the dynamics of nail biting. However, his assumption that con-

tinued finger-nail biting is a symptom of an incompletely resolved Œdipus situation appears to be too comprehensive a generalization in view of other experimental findings.

The findings of another outstanding analyst, K. A. Menninger,[1] are somewhat similar to those of Wechsler. Menninger viewed nail biting as a form of self-mutilation, indicative of both punishment and indulgence. He thought that by punishing the self, an excuse was set up for further indulgence, so that the habit became more deeply ingrained and perpetuated.

Menninger agreed in part with Wechsler about the relationship between nail biting and masturbation. He pointed out that mechanically the parallelism was obvious: the fingers; instead of being applied to the genitals, were now applied to the mouth, and instead of the genital stimulation, there was the labial stimulation accompanied by the punitive (mutilative) element of biting. The punitive element in nail biting represented self-punishment arising out of guilt feelings concerning masturbation. With respect to the masturbatory and punitive nature of nail biting, Menninger concluded:

> ". . . the neurotic child because of his fear of punishment stops masturbating and substitutes nail biting . . . which is regressive in the sense that it harks back to the earlier days and ways of pleasure—namely, oral instead of genital. It is then a substitute kind of gratification and a concomitant punishment simultaneously."

English and Pearson[2] considered nail biting along with thumb sucking and compulsive eating as "reactivation or prolongation of infantile pleasure habits." Specifically, they viewed the habit as an oral one which was an aggressive as well as a pleasurable act and which was found more often in children who were "smoldering with anger against some real or fancied disappointment from the parent." The child dared not vent his anger directly by biting the parent, as he wished to do, but, instead, expressed it by biting himself.

This viewpoint was brought out in a rather striking case

[1] See "A Psychoanalytic Study of the Significance of Self-Mutilations," by Karl A. Menninger. *Psychoanalytic Quarterly*, vol. 4, pp. 408–66, July, 1935.

[2] See *Common Neuroses of Children and Adults*, by O. S. English and G. H. J. Pearson. New York: W. W. Norton and Company, 1937.

description by Geleerd.[1] Her subject was a seven-year-old girl addicted to compulsive masturbation. The child also attacked her nails, which was interpreted as a substitute for her desire to nibble at her mother's breast. In the child's words, "I like to nibble at my Mammy's breast; I hate my Mam, so I nibble at her breasts. . . . I love to nibble like a mouse; therefore I nibble at my nails; oh, I do like to nibble at my nails."

Again, as in the case of Wechsler's formulations, we are apparently dealing here with a highly generalized explanation of behavior. It is dubious whether most children who bite their nails are symbolically biting their parents in a spirit of revenge.

Partial agreement with the Wechsler-Menninger-English-and-Pearson school is found in an article by Billig.[2] He stated that nervous habits are stereotyped non-adjustive motor acts which represent an infantile mode of response. They are, in his view, resorted to as a partial escape from tension, and are described as expressive of neuroticism, poor tension tolerance, and low morale. Billig did not agree with the analytic interpretation of nail biting as symbolic masturbation.

In his later article, previously mentioned, Billig[3] apparently modified his views of etiology somewhat. It may be recalled that he noted no significant change in the incidence of nail biting during the war years. This, he thought, was due to the fact that the inciting cause or causes are not usually obvious. With respect to etiology, he concluded:

> "It seems that marginal initiations set off nail biting. The biting appears to serve as an ameliorative for such irritations. The serious tensions do not seem to be directly related to nail biting, but are manifested in other behavioral responses of a more complex organization, such as dancing, talking, arguing, and fighting."

His explanation of the reason why some of the subjects had formerly bitten their nails, but no longer did so, was

[1] See "The Analysis of a Case of Compulsive Masturbation in a Child," by Elizabeth R. Geleerd. *Psychoanalytic Quarterly*, vol. 12, pp. 520–40, October, 1943.

[2] "Nervous Habits and Morale," by A. C. Billig. *Proceedings of the Pennsylvania Academy of Science*, vol. 16, pp. 51–3, 1942.

[3] "The Consistency of Fingernail Biting," *loc. cit.*

that these persons found the habit to be inconsistent with their ideas of themselves. Consequently they acquired equivalent mannerisms, which were more consistent with their personalities, some of these being cigarette smoking, gum chewing, and pencil chewing.

Another analyst, Levy,[1] went a bit further in his explanation of nail biting, stating that the behavior was not an accessory movement, but derived from the sucking movement and was a direct modification of it. He felt that the movements involved in nail biting represented "release of tension either in the lips, fingers, or teeth."

Physiological and Neurological Theories.—Closely related to the psychoanalytic studies of nail biting are those that postulate some neurological or physiological basis for the habit. This approach to the subject of nail biting seems to have received special favor on the continent, as shown by articles in the French journals.

Bovet,[2] after a study of four hundred and thirty-six nail biters, concluded that the habit represented both phylogenetically and ontogenetically primary auto-aggression and destruction. This special form of discharge was said to be shown because jaw movements were so important as outlets for tension.

Recognizing the rôle of social forces to some extent, Bovet pointed out that the nail biting gave maximum subjective effect because it was inconspicuous and reasonably inoffensive. Becoming somewhat symbolic and theoretical in his interpretation, Bovet pointed to another root of nail biting—the collective unconscious. He also referred to the magic significance of the nail, but did not explain this concept. It should be pointed out that, in a later article,[3] this point of view was modified to some extent.

[1] See "On the Problem of Movement Restraint: Tics, Stereotyped Movements, Hyperactivity," by D. M. Levy. *American Journal of Orthopsychiatry*, vol. 14, pp. 644–71, October, 1944.

[2] See "*L'Onychophagie. Contribution a l'Etude de la Pathologie de la Personne*," by L. Bovet. *Schweizer Archiv für Neurologie und Psychiatrie*, vol. 50, pp. 14–59, 1942.

[3] "*Quelles Aspects de l'Onychophagie Chez l'Enfant*," by L. Bovet. *Zeitschrift für Kinderpsychiatrie*, vol. 10, pp. 167–73, 1944.

Schachter and Cotte[1] pointed to the necessity for understanding the social environment of the nail biter, but, at the same time, they found certain physiological factors in the background of the nail biters. In studying one hundred cases, they found that 13 per cent of the nail biters had suffered from convulsions in their childhood; that 9 per cent had had premature dentition; and that 20 per cent had suffered from nocturnal enuresis, 34 per cent from slight mental deficiency, and 26 per cent from serious mental deficiency. No statistics from control groups were presented. Contradicting to some extent the idea that nail biting accompanies masturbation, and at the same time confirming to some degree the notion that nail biting is symbolic masturbation, Schachter and Cotte found that only 6 per cent of the nail biters were masturbators.

Giving an extremely mechanistic explanation of the dynamics of nail biting, Shahovitch[2] explained:

> ". . . a pattern has been established in his nervous system which is permanent and may reappear at any time in his life after prolonged or undue strain. The pathway of this pattern has been made over his nervous system and can never be entirely obliterated. It is an intangible wound, the repair of which is difficult and whose recurrence is frequent."

Shahovitch apparently recognized to some extent the importance of social stress in the etiology of nail biting and attempted to integrate this with certain biological factors. In this respect, she commented:

> "The child senses this anxiety and uncertainty and feels a terror of something unknown. We have inherited a primitive gesture of bringing the hands quickly to the face in moments of fear, and the child is close, biologically, to the instincts of his race. A beast, in terror, will gnaw when he cannot fight. A child brings his hands to his face in apprehension and soon learns to gnaw."

In line with more recent research, this author stressed the excessive emotional stimulation factor in the formation of nervous habits, but it appeared to play a secondary rôle, in her thinking, to the neurological bases outlined above.

Much the same approach was given by Bovet in his later

[1] See "*Etude Analytique de 100 Cas d'Onychophagie Chez l'Enfant,*" by M. Schachter and S. Cotte. *Annales Pædiatrici*, vol. 166, pp. 99–106, 1946.

[2] *Op. cit.*

article.[1] In this, he gave credence to social theories of nail biting, but also considered the habit as a symptom of physical stress, and emphasized the therapeutic value of rest periods and vitamin dosage. This is also seen in his comparison of the tension relief gained in nail biting to that of laughter and orgasm, drumming of the fingers, smoking cigarettes, and even suicide. Nail biting was seen in this frame of reference as a mechanism of reducing tensions of the physiological sort, common to everyday life.

Thom[2] stressed the physiological basis of nail biting and distinguished between the genesis of nail biting and thumb sucking. This distinction, which is contrary to the theories of the analysts, was made on neurological grounds: "many of the thumb suckers are calm, placid, unemotional children, while the nail biters are apt to be hyperactive, quick, fidgety individuals, with whom everything seems to register on the nervous system in an exaggerated manner." Duncan[3] also refers to "nervous, highstrung nail biters," but does not amplify the statement relative to etiology.

Further investigations designed to clarify the rôle of these postulated physiological and neurological factors in nail biting would seem to be highly desirable. Many studies are thought-provoking in connection with the possible rôle of the above factors in nail biting, but are so heavily weighted with psychological factors that no definite neurological conclusions can be drawn. For example, Berdie and Wallen[4] found that adult male enuretics were conspicuously high in the incidence of the following traits as compared with matched non-enuretic controls: lack of confidence, nervousness, nail biting, talking in sleep, somnambulism, and backaches.

Similarly Mahler and Luke,[5] in studying children addicted to various tics, found that nail biting, along with more gen-

[1] "*Quelles Aspects de l'Onychophagie Chez l'Enfant,*" *loc. cit.*

[2] See *Everyday Problems of the Everyday Child*, by D. A. Thom. New York: D. Appleton-Century Company, 1927.

[3] See "Fingernail Diseases," by E. T. Duncan. *Hygeia*, vol. 24, p. 679, September, 1946.

[4] See "Some Psychological Aspects of Enuresis in Adult Males," by R. F. Berdie and R. Wallen. *American Journal of Orthopsychiatry*, vol. 15, pp. 153–59, January, 1945.

[5] See "Clinical and Follow-up Study of the Tic Syndrome in Children," by Margaret S. Mahler, Jean A. Luke, and Wilburta Daltroff. *American Journal of Orthopsychiatry*, vol. 15, pp. 631–47, October, 1945.

eralized biting, spitting, and teeth grinding, was manifest in almost half of their cases. Explaining this, they commented:

> "In the habit of nail biting it seems that small amounts of the aggressive impulse reverted and were inverted in autoaggressive behavior. In this respect, nail biting would seem to have a psychodynamic meaning similar to the tensing up and breath holding attacks, the temper and screaming spells, commonly found in *tiqueurs.*"

Again, we do not know that all these symptoms found in the child prone to tics are not caused primarily by psychological rather than by neurological factors. In any event, our techniques of investigation are not adequate for the definite postulation of a completely physiological or a completely neurological basis for nervous habits.

Situational Anxiety and Social Stress.—Viets's [1] study in the early thirties was one of the first to repudiate the strict biological interpretation of nail biting. In a comparison of a group of nail biters with a group of children who did not bite their nails, she was unable to find any significant difference in intelligence or in physical condition. Also, the habit was not associated in her study with masturbation or with any specific behavior problem. Most important, the nail biter did not seem to be an essentially "nervous" child.

What Viets found of a positive nature was also of importance. She found that there were marked differences in the home environments of the nail-biting and the non-nail-biting children, the former having experienced many more situations of tension in their home life. She concluded that it was doubtful whether a habit such as nail biting could be set apart and be said to be due to one specific cause. Rather, she thought it logical to regard this behavior as "symptomatic in the individual's life, conscious or unconscious."

Viets emphasized the fact that "nervousness" was noted in only a third of the children who bit their nails and that a fourth of those in the control group were described as being nervous. It should be noted here that the control group was made up of behavior-problem children, who may have been more "nervous" than a general child population. In comparison with the average child, then, her nail-biting subjects may have been more nervous.

Also, it was not explained how nervousness was judged in

[1] *Op. cit.*

this study. In corroboration of her conclusion regarding nervousness, Viets quoted Ackerson and Leuton to the effect that the correlation between nervousness and nail biting was only about 0.25 to 0.30. However, it was again not stated what the criteria of nervousness were.

Viets further stated that there was no signficant relationship between nail biting and thumb sucking, grimacing, eye blinking, lip sucking, picking, easy movement to tears, or speech blocks. These findings were contradicted by the later results of Grinker and his co-workers,[1] Goldfarb,[2] Despert,[3] and Rottersman,[4] mentioned earlier. Restlessness, postulated by some authors as related to nail biting, was not a significant factor in Viets's data.

The social importance of nail biting was indicated in Viets's discovery that nail biters were more often disliked and had fewer friends than other children. Although she thought the children might resort to nail biting to cover up their insecurity, she did not find them socially seclusive or highly introverted, but, in contrast, more outgoing than her controls. Their academic records were average. Viets concluded that the material "does not show nail biting to be highly associated with any particular physical or personality type."

Substantiating the view that unhappy, strained environmental conditions have much to do with nail biting, Viets pointed out that there were far fewer intact family groups among the nail biters than among the control subjects. Homes that were not harmonious, in which there was an alcoholic or an immoral parent, in which there was constant quarreling—homes in which tension was the keynote, apparently produced a great number of nail biters. Overprotection and sibling jealousy also were found to be of importance in the dynamics of nail biting.

On the basis of her findings, Viets concluded that "a rather good case can be made for the hypothesis that nail biting is, in many cases, a reaction to a situation of deep emotional strain." She felt that nail biting was unconsciously fixated

[1] *Op. cit.*
[2] *Op. cit.*
[3] *Op. cit.*
[4] *Op. cit.*

upon, its positive values seemingly outweighing the negative cosmetic and social aspects.

Bovet[1] partially supported and partially disagreed with the findings of Viets. He found:

> "In a general way, the nail biter appears in comparison with the normal as more unstable, more superficial, and less disciplined. But it appears impossible to tie down in this way a certain invariable trait of character peculiar to the nail biter and *vice versa*."

He felt that nail biting was often resorted to as a means of reducing the anxiety growing out of uncertainty concerning the future. This was based on his finding that a majority of the children began to bite their nails at night before going to bed, a time he described as a "moment of anguish." Other times commonly known to be periods of increased nail biting were when the child feared not knowing his lesson, when reading a sad story, at a crucial point in a game when the nail biter was a passive spectator, and after a nightmare. Thus, he concluded that no more than enuresis was nail biting a malady in itself. On the contrary, it was found to be an indication of other difficulties.

Because only 27 per cent of the nail biters were required to undergo further, more detailed psychiatric investigation, Pennington and Mearin,[2] in their investigation of naval recruits, felt that the habit was not diagnostic of maladjustment. Numerous recruits who bit their nails revealed no other neurological or psychological symptoms sufficiently serious, in terms of the current military standards, to disqualify them. "It is only safe to conclude that nail biting cannot be used during rapid screening exams as an easy index to underlying abnormalities." Some significance was found in the recruit's attitude toward his nail biting. Those who denied it or became angry when it was pointed out to them were found to respond similarly in other situations, and generally were less adept in adjusting to military life, while those who faced the habit and felt that it was undesirable and should be conquered were not as likely to have other nervous manifestations.

The above authors felt that the habit in adult life was

[1] *"Quelles Aspects de l'Onychophagie Chez l'Enfant," loc. cit.*

[2] *Op. cit.*

illustrative of Allport's [1] principle of functional autonomy of motives in that most of the men reported that they acquired the habit in childhood and that they were not now conscious of the habit to any great extent. They stated:

> "This act, learned as it always is, comes gradually to possess its own motivating force and, hence, to run its course without undue external stimulation and without fulfilling any apparent need; the normal childhood need for expenditure of energy, evidenced in some children by nail biting, no longer exists. The habit in mature adults may thus merely illustrate the 'strangle hold' that an early response pattern can acquire in the absence of the original stimuli."

From this, they decided that the habit could not be diagnostic of abnormal conditions, and that it perhaps only showed that habits were maintained after the exciting conditions that caused them had ceased to exist.

In a later article, Pennington [2] again pointed to the diverse facts responsible for the initiation and continuation of this habit. "Obviously, the number of situations inducing this mannerism is large. Economic, social, familial, sexual, and all other bases for conflict and frustration have provided, among the thousands interviewed, a fertile ground for the generation of tensions." In this framework of multiple causation, nail biting was looked upon as a learned mechanism unconsciously directed toward the reduction of tensions. He stated that the explanation must be in terms of a multiple-factor interpretation, and he considered the early Freudian interpretations in terms of psychosexual development to be "more concealing than revealing. . . . Sexual frustration and conflicts, broadly or narrowly defined, cannot alone, in terms of the findings revealed by the nail biters examined in this study, be held responsible for the genesis of the mannerism."

Substantiating this statement was his investigation of topics pertinent to the Freudian interpretation, in which he found no significant differences in such things as marital status and heterosexual adjustment between a group of nail biters and a group of non-nail biters. He concluded:

> "To assume that the decrement in frequency in the upper ranges [of age] is the result of the attainment of heterosexual adjustment conceals

[1] See *Personality, a Psychological Interpretation*, by G. W. Allport. New York: Henry Holt, 1937.

[2] *Op. cit.*

> the dynamic interplay of social and personal factors operative in the total situation as well as interpreting too narrowly a mannerism widely prevalent in society."

Pennington stressed the need to include the factors of learning, frustration, conflict, and unconscious motivation in the interpretation of the nail-biting habit. The fact that from 25 to 30 per cent of the older blood relations of the nail biter were usually also addicted to this habit was said by Pennington to corroborate his emphasis upon the learned nature of the habit. Gaining its own motivational mechanism, the behavior no longer needed to be excited by a specific situation, but was self-perpetuating.

Pennington's views can best be summarized in his own words, which seem to have considerable basis in his extensive study of nail biting in the armed forces:

> "A working hypothesis is accordingly postulated. It assumes that nail biting is a tension-reduction mechanism; that it is usually acquired at a more or less unconscious motivational level; that learning by imitation via prestige suggestion can account for certain cases; that the habit once established may outlast the original inducing situation and hence persist; that loss of class membership, criticism, and ridicule play important rôles in the control of the mannerism; that the resolution of personal difficulties helps many (not all) to eradicate the habit."

The exact meaning of the habit was said to be a clinical problem.

Dunlap [1] also felt that the problem of nail biting was not an entity, but that "chewing the finger nails is always a symptom of a maladjustment, which may be minor, but is in danger of producing a comprehensive neurosis." In agreement with this view and with Pennington's as regards the meaning of nail biting, Sherman and Jost [2] stated that "the most common physical activities during frustration involved movements of the face, mouth, and hands. These movements can probably be interpreted in part as an attempt to escape from the frustrating situation and in part as a direct expression of emotional tension."

Several other authors have stressed the etiological significance of situational stress and anxiety in the formation of

[1] See *Personal Adjustment*, by K. Dunlap. New York: McGraw-Hill Company, 1946.

[2] See "Frustration Reactions of Normal and Neurotic Persons," by M. Sherman and H. Jost. *Journal of Psychology*, vol. 13, pp. 3–19, January, 1942.

the nail-biting habit. Hill,[1] in his study of evacuated naval and marine personnel, found that "in one-half of the patients, it happened when they were in tense, emotional situations." Another frequent occasion for nail biting was during periods of enforced inactivity.

From his investigation, Hill concluded that the military usefulness of the nail biter was somewhat less than that of the non-nail biter, but that some nail biters could undergo combat without hospitalization for nervousness. Those with the habit who were least suitable for combat were found to have certain patterns in their personalities, including such factors as unhappy parent-child relationships, multiple early neurotic traits, irritable explosive tempers, unusual reactions of weeping and trembling when angry, infrequent use of the fists in childhood fighting, and emotionally disturbed responses to combat killing. Strongest among these complaints were the unhappiness and frustrations in childhood.

A similar pattern was shown by Jones[2] among normal subjects under stress situations. Under the strain of working arithmetic problems, normal subjects were found to show a significant increase in certain nervous movements, of which "oral" and "manual" movements were the most marked. These included the "introduction of the fingers into the mouth" and finger picking.

Deviating somewhat from her neurological theory of the genesis of nail biting, Shahovitch[3] commented that:

> "... one of the underlying causes of nail biting in the modern American child is that he has so little occupation for his hands—so little responsibility. He is not taken into the family confidence and given his share of work to do. He is out of the life of the family and the world, and he feels it. The child with the greatest potential sense of responsibility is sometimes the worst nail biter."

Contradicting Michaels,[4] who, it will be remembered, found no significant difference between the amount of nail biting among delinquents and their sibling controls, Shahovitch stated that a majority of juvenile delinquents were nail biters.

[1] *Op. cit.*

[2] See "Studies in 'Nervous Movements': I. The Effect of Mental Arithmetic in the Frequency and Patterning of the Movement," by M. R. Jones. *Journal of General Psychology*, vol. 29, pp. 47–62, July, 1943.

[3] *Op. cit.*

[4] *Op. cit.*

She added, however, that a majority of nail biters were not delinquents. Children of either an exceptionally high or an exceptionally low I.Q. might be expected to be unstable and hence bite their nails, according to this author.

The habit of nail biting was not considered by Shahovitch as repressive behavior, but rather as a mature reaction. She distinguished it carefully from infantile sucking habits, and felt that the outcome of sucking habits was more favorable than that of nail biting. Despite all this, however, she concluded that all the workers agreed that nail biting showed "an unstable condition of the nervous system."

In one respect, Shahovitch's work parallels that of the ecological studies of Faris and Dunham [1] on mental ill health in Chicago. She claimed that the incidence of nail biting in kindergarten-age children was rare in a district of permanent home-owning families, but that in districts of transients and so-called broken homes, the nail-biting child appeared much more frequently. She thought that modern American life was peculiarly conducive to the formation of nail-biting habits. She considered that the child was often no more than a biological error—"his hunger is appeased by whatever the family likes. His bed hour is when he falls asleep. His emotions are guided not at all. And then the parents get a divorce and remarry and the situation goes on." Such grossly unadjusted homes would not, it seems, be model in our society.

Spock [2] also pointed to the accumulated parent-child tensions as the basis of later behavior problems. These tensions were said to arise out of everyday situations that might have been avoided.

Essentially this same point of view, but stated more conservatively than that of Shahovitch, is that of Maberly [3]:

> "Many children react quickly and violently to relatively minor changes of environment, and they respond quickly to proper therapy, because the material is pliant and growing fast. Symptomatic treatment as such is

[1] See *Mental Disorders in Urban Areas: An Ecological Study of Schizophrenia and Other Psychoses*, by R. E. L. Faris and H. W. Dunham. Chicago: University of Chicago Press, 1939.

[2] See "Avoiding Behavior Problems," by B. M. Spock. *Journal of Pediatrics*, vol. 27, pp. 363–82, October, 1945.

[3] See "Psychology in General Practice; Problems in Childhood," by A. Maberly. *Practitioner*, vol. 151, pp. 362–69, December, 1943.

rarely of value. As the child himself is changing so rapidly, he cannot tolerate surroundings lacking in constancy aand certainty. He may be more affected by change of place than human companionship."

In a highly popularized, but seemingly scientifically sound article, Bevans [1] paralleled the above view when she said that "nervous physical tensions based on emotional disturbances might be responsible for a young person biting his finger nails." Cessation, conversely, was said to be a function of freedom from the emotional strains. The overprotected child, as well as the child who received insufficient attention, was described as a potential nail biter. Such a child might feel oppressed by the constant loving supervision and become bored and aimless, biting the nails as a form of protest. Kanner [2] supplied a similar theory of nail biting, calling it an expression of psychomotor tension.

In summary, we have seen that there are many sorts of explanation for the behavior termed nail biting, despite the fact that the actual amount of scientific work done on this subject is small. Explanations of the habit range from the neurological theories, through the psychoanalytic theories, to the socio-psychological theories stressing situational and environmental stress.

Further information concerning the etiology of nail biting may be gained by a study of the various therapies that have been advanced for the curtailment of this behavior. The therapy, obviously, will vary somewhat with the theoretical orientation of the given clinician. However, it is surprising, in view of the wide differences of opinion relative to etiology, to note the unanimity of opinion with respect to therapy.

THERAPY

Virtually all of the investigators are in agreement with Thom,[3] who commented that "nail biting may be treated by many of the same measures that are used for thumb sucking. Bitter applications, however, are of less value, and restraint is invariably more harmful, because nail biting is more apt

[1] "Biting the Fingernails," by Gladys H. Bevans. *Woman's Day*, vol. 18, pp. 58–59, December, 1945.

[2] See *Child Psychiatry*, by L. Kanner. Springfield, Illinois: Thomas, 1935.

[3] *Op. cit.*

to be found as part of the picture in the neurotic child than is thumb sucking."

Louttit[1] agreed that such measures are undesirable:

> "Corrective procedures utilizing restraint or bitter applications are even more contraindicated for nail biting than for the thumb sucking. Therapeutic measures must be aimed at relieving the underlying tension, and this involves treatment of the child's whole personality."

Further corroboration came from Schachter and Cotte:[2]

> ". . . the application of bitter substances have not, so to speak, cured any one. It is in studying the child, in knowing his environment, his physical, alimentary, emotional, and social difficulties that we have the greatest chances to cure it. . . . Nail biting must be studied carefully and it is only the knowledge of the personality of the subject and of his surroundings that will permit the finding of the best therapeutic solution."

Agreeing that the painting of the fingers with bitter-tasting preparations is of little value, and granting that we must seek a more generalized treatment than this, there still remains the problem of what this treatment should be, how specific it should be, and whether it should be on the individual or on the societal level or on both.

In line with the neurological theories of the genesis of nail biting, there have been suggested certain "cures," based upon the substitution of another manipulation for the activity of nail biting. These cures are based upon the premise that there is always some physical need to discharge energy over certain neural pathways, and that some other manipulatory act can serve this end as well as nail biting. Shahovitch,[3] for example, suggested urging the child to push its cuticle back instead of biting the nail. It was she, it should be remembered, who postulated a pathological condition of the nervous system as the basis of nail biting. Despite this, she also mentioned preventive measures, such as less nervous stimulation and an increase in positive employment. If the habit has already begun, Shahovitch suggested that we "try to find the disturbing factor."

[1] See *Clinical Psychology*, by C. M. Louttit. Revised edition. New York: Harper and Brothers, 1947.

[2] *Op. cit.*

[3] *Op. cit.*

Wechsler,[1] in his comments on therapy, stresses the symptomatic nature of nail biting, as opposed to its true habitual nature. Thus, for him, all methods aimed at breaking the habit of nail biting are of no avail:

> "They are not only useless, but injurious because they merely serve to fix or at best displace the symptom. So also is probably the effect of calling attention to or constant harping on the 'habit' and the infliction of punishment on the child for failure to desist, in any form. For an understanding of the significance of the 'habit' shows us at once that by the former method we merely serve to increase the child's feelings of guilt, and by the latter serve to gratify its need for punishment. Such gratification, really absolution, merely enables the individual to continue more stubbornly the activity from which we are trying to wean him. The only way to treat nail biting, as in the case of any other symptom, is to attack the cause and not the symptom itself."

One of the selections in *Psychiatric Interviews with Children*[2] is that of the case of Marie LeFevre, a girl of fifteen who was troubled with compulsive stealing and who also bit her nails. In the therapy situation, the girl expressed guilt over her nail-biting habit, but the therapist was quick to comment that she did not feel the habit morally wrong. The following is an excerpt from the interview:

> "Marie looked surprised and a bit anxious. 'First,' I said, 'I imagine it's uncomfortable, for nails protect a sensitive part of the finger, so when the cuticle is torn, the fingers are particularly sensitive.' She agreed. I asked how she herself felt about her nails. Marie said she would like to have long, painted nails, like some of the girls. She would get a manicure if she had nails like that. I laughed and said, 'Why wait? I agreed that manicured nails would probably look better if they were fairly long, but I thought that the manicure might act as a reminder when she wanted to bite her nails.
>
> "I then added, 'You know, Marie, it's been my experience that most people bite their nails when they are tense and anxious. Now you don't appear to be an uncomfortable, uneasy person, but I really wonder if you are as happy and satisfied inside as you seem to be on the outside. I say that because of your nails. What do you think?' She became quieter, gazed out of the window, put her fingers to her mouth, removed them, and smiled in an attempt to cover her embarrassment. 'Maybe it might be interesting to check that yourself,' I said. 'When you find yourself biting your nails, ask yourself what you are thinking about, or what your feelings are, and see if it happens to be an unhappy feeling.'"

In this interview it can be seen that the therapist accomplished a number of things. She clarified her positive atti

[1] *Op. cit.*

[2] By H. L. Witmer. New York: The Commonwealth Fund, 1946.

tude toward the patient, in contrast to those who condemn or punish the behavior. She took advantage of the discomfort of ragged, short nails and the patient's desire to have long painted nails like other girls, to suggest an immediate manicure, which might increase the girl's interest in keeping her nails properly and help to prevent further nail biting. She also helped the girl to gain insight into her habit by explaining that most persons who bit their nails are anxious and tense, and suggesting that the girl check on the situations in which she bit her nails. In the further elucidation of the therapeutic situation, it was shown that nail biting, as such, could not be attacked effectively in too forthright a manner, but that it would tend to resolve itself as the larger, more inclusive problem, which in reality led to the nail biting, was solved.

Knight [1] also recognized the secondary nature of nail biting. He pointed out that persistent thumb sucking or nail biting beyond infancy was used as a means of soothing anxieties.

As *preventive measures,* he suggested the application of affection from both parents, and consistent, firm discipline, prompted by the child's need, not by the parents' comfort. He thought that these things tended to make the child feel more secure, and hence less anxious and helpless in relation to his drives. Understanding and tolerance were considered of primary importance by Knight in his discussion of therapy.

It may be noted that the nail-biting habit is usually not considered socially desirable by the parents and friends of the nail biter, who often direct attention to this behavior. This may be constructive, but more often it appears in the nature of nagging and scolding. The patient may then become the center of attention and may utilize his habit to maintain this prominence if it is important to him. In other cases, the parental attention leads to further feelings of insecurity and inferiority, thereby undermining the psychic security of the nail biter. In both of these situations, overemphasis on the habit serves to ingrain rather than to dissipate it.

[1] "Behavior Problems and Habit Disturbances in Pre-adolescent Children. Weaning and Management," by R. P. Knight. *Bulletin of the Menninger Clinic,* vol. 8, pp. 188–99, November, 1945.

Consideration such as the above led Thom[1] to suggest that, while oral habits of this sort should not be ignored, neither should they be given too much attention. Thom concluded that most persons at some time in their development fall victim to these habits, and the best way to rid the child of them is to lead him gradually away from them with intelligent guidance and minimal directing. He pointed out that overemphasis upon the habit served only to focus attention upon the child, and to make him seem different. Thom concluded:

> "... parents should be warned not to give these ... habits too much attention. By that, one does not mean that they should be ignored, but that the child must be led away from them gradually. Most people, at some time or other, have one or more of these habits. ... Through intelligent guiding, with not too much directing, the habits have disappeared. If the importance of the habit is exaggerated, it only serves to keep the eyes of the entire household upon the child. He becomes a much discussed individual, who is looked upon as being different. With this comes at first an unconscious sense of satisfaction. The child, however, soon learns to capitalize this interest in him. The constant 'don't' is the best way to keep the child's attention on the habit and the easiest way to build up resistance."

Thom suggested diversion, either new or reactivated interests, that would serve as outlets for the child's anxiety. In a non-neurotic child, in whom the habit is an isolated bit of behavior, Thom thought that pride might be an aid to the parents in their attempts to put an end to the nail biting. Building up interest and pride in cleanliness, manicures, and well-groomed hands was considered an effective method of therapy. In this connection, Thom pointed out that the child would often take an interest in improvement when he saw tangible evidence of success.

Shahovitch,[2] aside from her biological approach to the problem, also stressed these factors in the curtailment of nail biting. She believed that the child must be given a sense of responsibility and feelings of adequacy. An apt statement in her article describing the nail biter is: "his condition is mainly a reflection of the world about him. And above all ... don't scold or shame him."

In Bevans' article[3] some final general comments were

[1] *Op. cit.*
[2] *Op. cit.*
[3] *Op. cit.*

given which again pointed up the need to understand and guide the anxious nail-biting child. Bevans stated that since we could not expect conscious or consistent self-control from a young child, the habit must be ignored most of the time by the entire family. Praise should be liberally used whenever there were any good results.

Bevans also suggested a general physical examination to seek out any causes for nervousness, and a balanced day, including activity, good food, and ample rest. She considered this as the essential basis for all other more specific therapy. "Activity should not only be the vigorous muscular outdoor kind with sports and play, but life should be rich with a growing child's interests; opportunity to use mind and hands and emotions in creative play, in the arts, mechanics, and handcrafts."

Asked about rewards in connection with attempts to stop the habit, Bevans was inclined to think that they are not wise. However, she thought that in some cases a sufficient incentive could be created to make the child readjust his behavior and as a result cease biting his nails; in this case no harm would be done.

The above discussion of therapy would seem to emphasize the relation of nail biting to environmental stress and its importance as a tension- and anxiety-reducing reaction. In view of its symptomatic nature, most investigators agreed that therapy should be along the lines of reduction in environment stress and strengthening of the personality in terms of adequacy and security.

SUMMARY

In summarizing the above review of the literature on nail biting, the following points seem to be of primary significance:

1. Nail biting was found to be of common occurrence in the general population. In general, it was found to exceed 25 per cent among school children and 20 per cent among naval recruits and other selectees for the armed forces in World War II.

2. The incidence of nail biting was found to be significantly higher among certain special groups, including children reared in institutions, stuttering children, neuropsychiatric

rejectees, men diagnosed as having severe operational fatigue, and naval and marine personnel evacuated from combat areas for nervousness in World War II.

3. The incidence of nail biting was found to be greatest during the general adolescent years, decreasing thereafter with increasing age.

4. Nail biting was not found to be an adequate basis for diagnosing maladjustment, but it was found to occur more frequently among those considered maladjusted.

5. The explanation of the dynamics of nail biting varied with the theoretical orientation of the particular investigator. In general, psychoanalytic approaches stressed the onanistic equivalence of nail biting, its circular action as both a satisfaction and a punishment, its relation to an unresolved Œdipus situation, and its connection with regression to or fixation at a fundamentally oral stage of development. Neurological and physiological theories varied considerably and seemed inadequate as a general basis for nail biting. Various theories related to the rôle of nail biting as a means of tension reduction under conditions of situational stress.

6. It would appear from the literature that the dynamics underlying nail biting may vary considerably from one subject to another, and that any or all of the above points of view may be involved in explaining the etiology in a given case.

7. Despite differing points of view with respect to etiology, most investigators are agreed that the symptomatic treatment of nail biting by restraint, bitter applications, scolding, and threats is of little value. They have emphasized understanding, tolerance, the reduction of environmental stress, increased adequacy feelings, and the provision of a more satisfying way of life as essential to adequate therapy.

8. The need for additional studies in this area would seem of importance in view of the widspread incidence of nail biting and its apparent relationship to personality maladjustment.

WHEN A COMMUNITY WANTS A CHILD-GUIDANCE CENTER *

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I THINK that I have been asked to discuss the subject of community readiness for a child-guidance clinic because, in this instance, I am able to speak about Delaware County, which has, by the efforts of numerous keenly interested persons, lately passed the test of eligibility for such a service. A community, I think, is ready for such a specialized agency as a therapeutic child-guidance service only when the other agencies, dealing with more general problems, are well established, and when they discover, in the delineation of their jobs, that the need for psychotherapy for children remains unmet. When the existing agencies are thus able to realize that they cannot provide the required service—that by its nature it must come from a special source—the implication of their inadequacy is removed. All this makes for harmony—a valuable thing in social service.

Delaware County is an area so close to Philadelphia and so varied within itself that for a long time it contained one group of citizens whose life and work centered locally in some one of its numerous businesses, and another group who lived in the county, but whose business and social life centered in Philadelphia. The separation of these two groups was so profound that they scarcely spoke to each other, much less considered each other's needs and way of life as bound essentially together.

In the past Philadelphia has made its skills and its resources available to what it called "outlying districts"; its attitude of responsibility and magnanimity has been consistent and generous. From association with the top-flight agencies in Philadelphia, it became increasingly evident to certain alert members of our community that they desired—yes, and needed—time and skill created particularly for their own community.

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It is possible that the growing urge for a more convenient clinic, designed more closely to meet local need, coincided with the growing and complex difficulties inherent in a concentrated centralization in a large city, which is practically strangling itself in its own traffic. There was not any small attitude of "We'll do it for ourselves. You mind your own business," about this, but a readiness to learn and to achieve coöperative levels, with the acceptance of mature responsibility for function, which has brought about an interesting equality of status and respect.

During the ten years of my active association with community organizations in Delaware County, I have enjoyed watching the development of county consciousness and county strength, the development of self-respect and, gradually and recently, the definition and delimitation of the functions of the several agencies. It is within this area of defining function and its limitations that a community develops good schools that are really devoted to education; good relief workers, capable of dealing with the problems immediately related to financial assistance; good family service, with its skills focused on the interpersonal relationships of family life; good children's aid, responsible and ready to function in areas where parents are insufficient.

The juvenile court is an essential part of a county program and its integration into this fabric depends on the perspective of the judges and the ability of the other agencies to interpret their functions to court officers. I have heard more than one probation officer say, "They won't coöperate with me," when he did not know what *they* did!

In this development of community consciousness, there have been several stages. Initially, there was a move away from the fault-finding attitude which is inseparable from a rejection of responsibility. This is an important phase to recognize, for it is at this period that requests for the establishment of a guidance clinic may be received. The attitude is, "There is something wrong, very wrong. We'll get some one in here to fix up all these problem children we have. We are enlightened—we know you shouldn't just clap them in jail—so we'll just get a clinic and that will take care of the problem." The

complacency and projection of responsibility in such remarks are obvious.

There is an occasion on record in which a child-guidance clinic was established at the urgent request of a community that had not gone through the process of self-development in meeting the more widespread problems that exist in every community. It had not the community structure to support this very specialized therapy. The clinic was presently closed, for the burden of rejecting cases not suited for therapy created misunderstandings and hostilities that eventually blocked its effectiveness. These same cases, unsuited to therapy, are the very case load of other agencies with other functions.

I have seen communities go through such definite phases in acquiring resources that the sequence seems almost necessary in the course of development. First, there is the phase of recognition that a problem exists, which coincides with an attitude of pessimism—"There's nothing we can do about it." Then some one suggests that some nearby community is doing something about it, and there begins a use of and a dependence upon this outside resource. Finally there develops a desire to be more self-sufficient and an eagerness to resolve on a local level the problems locally produced.

To think that this might be done without due regard for the special skills that must be brought to bear on such problems would be to underestimate a developed community's demands. The know-how may have to come from elsewhere, but it can be adapted to local needs. The choice of the executives in its agencies determines the vision and the coöperativeness possible in the total structure.

It has been found that to recognize one's own limitations takes quite a person—or quite an agency. It takes an even bigger person or agency to go a step further, and while retaining one's own function, to work toward the establishment of resources that are outside of one's province. In the analysis of the functions of the agencies that developed in Delaware County there continually stood out the fact that, effective as each might be, nobody in the county was taking care of children whose personalities were more than superficially disturbed. In a survey of psychotherapeutic resources for children in the area of Philadelphia and its vicinity, deficiency

of treatment was a glaring fault. On further study, it was found that not only was the county aware of an unfulfilled need for child therapy, but that already 10 per cent of the Philadelphia Child Guidance Clinic case load came from Delaware County.

It is at this point of development in a county's agencies that a recognition of a serious lack in their common load leads to a request that a child-guidance clinic be established. In this instance, it led to a request to the Philadelphia Child Guidance Clinic that it consider undertaking a service in Delaware County—not just as a traveling branch of a city clinic, but as a center that would grow to be an entity in Delaware County, having an equal place with other key parts of a child-guidance program which might in time cover the entire area of planning for Philadelphia and vicinity.

Let me say here that in undertaking the expanded perspective and interrelationship inherent in this project—which is just as new for the Philadelphia Clinic as it is for Delaware County—there is a move from local points of view on both sides. It may amuse you to think of Philadelphia, generous as it has been of its resources, as local-minded, but I can assure you that it is one process for a giant to be generous in his strength, and quite another for him slowly and painstakingly to go through the labor of helping others grow in strength. It is an equally large move for a district long patronized as "outlying" to lose its dependent, fearful attitude to a "giant," and with all humility learn to use the special skills that make strength, while still retaining its sense of separateness and innate individuality.

Delaware County is proud that it has met the qualifications necessary to be accepted by both the Philadelphia Child Guidance Clinic and the Community Chest for this new project. We are aware of the task of mutual understanding and interpretation that lies ahead, and we feel, as we felt a year ago when this request was first made, that we are on the verge of an experience that will be vital and expanding for all who share in it.

OUTCOME OF MENTAL-HOSPITAL TREATMENT IN NEW JERSEY

A STATISTICAL REVIEW OF STATE MENTAL-HOSPITAL ACTIVITIES

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THE sustained aims of those administering the state mental hospitals in New Jersey have been to maintain them as places of active treatment—medical, surgical, psychiatric—with all the allied physical and occupational therapies that modern science has devised.

It has been the consistent policy of the New Jersey State Department of Institutions and Agencies which supervises the state mental hospitals to give the medical officers complete freedom, within the range of financial limitations, to determine and carry out policies of treatment and care. Consequently, the three state mental hospitals have come to place varying emphasis upon therapeutic procedures in their medical and surgical services, dietetic oversight, activity and recreational programs, social-service supervision, and the like.

Thus the mental hospitals have, over a period of years, served as social and scientific laboratories in the testing and utilization of theories and procedures that have from time to time won the support of reputable medical men who had the responsibility for the formulation and conduct of a program that would help their patients to recover from their mental difficulties.

The development of the newer techniques in mental-hospital treatment and the application of the varying medical, surgical, and psychiatric measures make it highly desirable to institute an "audit," as it were, to attempt to measure as concretely as possible the effects of these efforts.

It would seem to be quite germane, therefore, to seek authoritative answers to questions such as the following:

1. What proportion of psychotic patients entering a mental hospital may expect to return to the community, and how soon? How are discharges, length of stay, and possibility of return to the hospital affected by the type of mental disease?
2. Is there a period when treatment is most effective? After what time is it necessary for a hospital to plan long-time or permanent care for a patient? On what basis can a hospital figure the expected increase in its resident population, from the accumulation of undischarged cases?

As background material to this study, it may be of interest to present here very briefly figures on the more recent trends in the hospitalization of mental patients in New Jersey. In the sixteen-year span, 1930–1946, the average patient population in state and county mental hospitals increased from 10,739 to 17,333, although it is to be noted that in the last five years there was a decided slowing-up both in the number of hospital admissions of mental patients and in the accumulation of patients in mental hospitals. The figures by years are as follows:

	Patients in state and county mental hospitals		*Rate per 100,000 general population*	
Fiscal year	Average census	Number of first admissions	Average census	Number of first admissions
1930	10,739	2,722	265.7	67.4
1935	14,095	3,001	343.7	73.2
1940	16,420	3,271	394.7	78.6
1941	16,605	3,502	399.1	84.2
1942	16,917	3,608	406.6	86.7
1943	17,042	3,358	409.6	80.7
1944	16,987	3,344	408.3	80.4
1945	17,143	3,465	412.1	83.3
1946	17,333	3,674	416.6	88.3

The present study of the outcome of mental-hospital treatment includes more than 4,600 patients cared for in the three state mental hospitals—Greystone Park, Marlboro, and

Trenton—during the three fiscal years, 1944–1946, and covers primarily the so-called "functional" psychoses as follows:

Psychosis	*Number of patients*
Involutional	602
Psychoneuroses	407
Manic-depressive	1,232
Dementia præcox	1,972
Paranoia and paranoid condition	153
Psychopathic personality	245

In regard to the age composition of the patients studied, the figures below classify them in broad age groups:

	Age of first admissions		
Psychosis	Per cent under 25 years	Per cent 25–39 years	Per cent 40 years and over
Involutional	0.0	3.3	96.7
Psychoneuroses	16.5	47.6	35.9
Manic-depressive	15.2	46.6	38.2
Dementia præcox	32.3	51.0	16.7
Paranoia and paranoid condition	0.8	24.6	74.6
Psychopathic personality	28.6	47.6	23.8

The extent to which the three state mental hospitals have been able to apply the various treatment methods and "move" patients out of the hospital is commonly measured by the number of discharges per hundred total admissions of a specified year.

In the following table are given the number of admissions and discharges alive for six specific psychoses of the so-called functional types covering the period 1944–1946, as well as the rate of discharges per one hundred admissions:

Psychosis	*Number of admissions*	*Number of discharges*	*Rate of discharges alive per 100 admissions*
Involutional	602	427	70.9
Psychoneuroses	407	393	96.6
Manic-depressive	1,232	1,041	84.5
Dementia præcox	1,972	1,181	59.9
Paranoia and paranoid condition	153	131	85.6
Psychopathic personality	245	218	89.0

In studying the data below on the length of stay of the patients included in this report before discharge, it is most gratifying to note that a large proportion of the patients were obliged to remain in the mental hospitals for not too prolonged periods:

	Duration of hospital life of first admissions before discharge		
Psychosis	Per cent under 6 months	Per cent 6–11 months	Per cent 1 year and over
Involutional	73.1	16.6	10.3
Psychoneuroses	84.0	10.1	5.9
Manic-depressive	77.7	11.9	10.4
Dementia præcox	54.2	19.3	26.5
Paranoia and paranoid condition	50.0	18.4	31.6
Psychopathic personality	58.3	15.9	25.8

It is important, of course, to secure as rapid a "turnover" of mental-hospital patients as is feasible, but also to see that as high a proportion of patients as possible go out of the hospital with restored mental health. The following figures illustrate the extent to which mental-health recovery has been achieved among the six specified patient groups:

	Condition on discharge		
Psychosis	Per cent recovered	Per cent improved	Per cent unimproved
Involutional	54.4	41.2	4.4
Psychoneuroses	26.7	61.8	11.5
Manic-depressive	58.4	36.2	5.4
Dementia præcox	7.6	85.3	7.1
Paranoia and paranoid condition	26.0	67.1	6.9
Psychopathic personality	66.5	30.7	2.8

The criteria of the degree to which mental-hospital patients have recovered their mental health are the established criteria:

> *"Recovered,"* indicates the condition of a patient who has regained his normal mental health, so that he may be considered as having practically the same mental status as he had prior to the onset of the mental disorder.

"Improved," denotes any degree of mental gain less than recovery.[1]

Another statistical analysis of outcome of treatment, and perhaps more valid than the usual studies in which discharge rates are applied, is to follow through in their "careers" a group of patients who had never before been in a mental hospital, and observe their status at uniform intervals after the admission period.

Such a statistical study offers a somewhat more authentic yardstick with which to measure the rate at which patients move through the hospitals, and the treatment policies which influence that rate.

The results of such an "outcome" study is presented here, covering 500 manic-depressive and dementia-præcox patients committed to the state mental hospitals for the first time in 1930 and followed through for the subsequent eight years. Tabulations were based on the whereabouts of the individual patient at the end of each twelve months after his *own* admission, noting his status at that time without regard to the intervening happenings in the life of that patient, such as return from parole or readmission after discharge.

The emphasis in the study has been put on the committed patients rather than on the voluntary patients, since the former make up the bulk of cases and are the types that are released on the recommendation of the staff physicians. Voluntary patients leave the hospitals merely after giving three-days notice.

Whereabouts of 500 committed manic-depressive and dementia præcox patients discharged from state mental hospitals in 1930

	Per cent released	Per cent in hospital	Per cent died
After one year	51.5	41.7	6.8
After two years	55.4	36.0	8.6
After three years	60.1	29.9	10.0
After four years	60.6	29.1	10.3
After five years	60.2	28.8	11.0
After six years	60.2	28.1	11.7
After seven years	61.4	26.5	12.1
After eight years	62.1	25.5	12.4

[1] See *Statistical Manual for the Use of Hospitals for Mental Diseases.* Tenth edition. New York: The National Committee for Mental Hygiene, 1942.

These figures show that the chances for release in the first year of hospitalization are considerably greater than in the second year, and that after the third year, the percentage released is practically stationary. The number remaining alive in mental hospitals gradually declines as deaths occur among them.

Enough authoritative statistical data have been presented here to show that the results of the curative work of the state mental hospitals are definitely encouraging. The task immediately ahead is:

1. To continue our efforts to transform existing mental hospitals into modern treatment and curative institutions. This means the provision of adequate treatment facilities and a trained medical staff, with consultants to carry on intensive treatment work, using the approved methods of treatment applicable to these patients.

2. To extend psychiatric social service or follow-up field work, so as to enable mental hospitals to parole early, under proper conditions and safeguard, a greater number of patients who can be satisfactorily adjusted in the community.

3. To extend the system of mental-hygiene clinics based on the mental hospitals to serve the communities in the diagnosis of mental and nervous disorders, and to reach potential sufferers from nervous or mental disorders before the definite breakdown occurs.

There apparently is a long road ahead in society's efforts to conquer the problem of mental illness, but research that is in progress and the new techniques that have passed from the stage of research to that of active use provide assurance that we can look forward to a day when further new discoveries will enable physicians and psychiatrists to achieve results as yet beyond our capacities.

THERAPEUTIC IMPLICATIONS IN THE USE OF THE GROUP IN RECREATION WITH PSYCHOTICS

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THAT recreation for the patients is an important part of a mental-hospital program has been recognized by hospital staffs for some time. Its value for patient as well as for non-patient is taken for granted not only by the professional, but by the layman as well. Because it is recognized as an essential and normal need of the individual, it is important that we reëvaluate our recreation goals and consider them in the light of their therapeutic possibilities in our constant efforts to help patients move toward health.

Through recreation activities we try to make use of whatever of the mental patient's personality remains accessible, and to provide pleasurable experiences and stimulation to help him in his progress toward health. We know from experience that where nothing is provided for patients in wards, in reality we are contributing toward the patient's withdrawal into himself and his own personal problems. There is a definite responsibility on the part of the hospital to provide recreation in some form, since recreational activities are part of the normal person's program, and the patient must be continuously subjected to as many normal experiences as possible. Recreation is one effective way to counteract the monotony of mental-hospital life, to provide topics of conversation, and to give the patients something to which they can look forward. It provides a means of constant attack against the patient's tendency to preoccupation with his life of phantasy, and brings continuous pressure to bear to bring him back to reality situations.

In considering the positive contributions that can be made in recreation therapy, we must recognize that the therapist has two sources or aspects of life experience with which to

work. The first is the use of human contacts or the relationships amongst the patients and the therapist; the second is the use of activities. In the first aspect, there are opportunities for providing positive social relationships with other people, including the recreational therapist; in the second, there are opportunities for creative and constructive recreational activities. Actually, the two aspects operate simultaneously and cannot be separated except for purposes of clarifying our thinking.

In this paper we will consider the first aspect—the use of the social relationships—to see how the recreation leader can use the group and the dynamic processes of interpersonal relationships to attain certain therapeutic goals.

The recreation leader, in his relationship to members of the group and in other contacts with individuals, can give positive emotional support. One of the greatest needs of mental patients is ego strengthening. The therapist must be a warm, accepting person, with an understanding of the dynamics of the patient's illness, who will give the patient the dignity, respect, and positive feeling that he needs. He must use this positive feeling that he has for the patient as the basis for continued contact until he can build a good relationship with the patient. After the latter has been able to accept the recreational therapist and to recognize these positive feelings, the therapist can help him establish meaningful relationships with other patients on the wards, and to become a part of social groups and activity groups. The following example, taken from one of our group records, points up the leader's warm, accepting feeling, how this is used to help the patient relate to others, and how the patient's hostile feelings can be handled effectively:

> "Florence said, 'No, I'm not coming to the group or I'm not going to do anything any more in this God-damn hospital.' She went on to say, 'It's no use to pray when your prayers aren't answered.'
>
> "The leader asked her what she wanted most and she said, 'I want to go home so bad.' This was said in a pitiful, whining voice. She continued, 'But all this hospital can think of is to give me those awful treatments. I thought I was going to die. I could hear everything every one was saying, but I couldn't say a thing. Besides, you bite your tongue, and, oh, it's awful! Nobody likes me and I might as well be dead.'
>
> "Florence's voice got higher and higher. She was shouting at the leader, with much interjection of profanity. . . .

> "In a very low voice the leader said that *she* liked Florence and would be sorry if Florence couldn't come to the group, because the group was one place in which she could do exactly as she pleased. Florence came."

We find that in addition to the support the patients get from the therapist, they can get emotional support from one another. In our recreation groups, we provide settings that encourage the development of interpersonal relationships among the patients, and the patients can use these relationships for mutual emotional support. Positive emotional support from associates is important in any setting. We emphasize it here because we must fact the fact that, in any present-day public-hospital setting, our psychiatrists and other therapists have such a heavy load that they cannot begin to meet this need of the patients for emotional support. Our experience has shown that individuals do help one another by accepting one another as people with feelings; that they overlook personality peculiarities and idiosyncracies, and make allowances for variations in behavior. Let me illustrate this with an excerpt from another group records. The leader writes:

> "This older woman patient is referred to by all the other patients as 'Grandma.' All the patients like her because they say she is a good sport. When 'Grandma' is not in a game, they will go over to her chair and help her up and try to engage her in whatever the group may be doing. They found out that she did square dancing when she was younger. They pulled back the table on the ward and another patient chose her for a partner, and when they had attempted the dance, all the applause from other patients seemed to be for this older woman."

The value of the experience in group activity to the individual patient has a direct ratio to the emotional support and acceptance he feels he gets from the other patients in the group, and his ability to identify himself with the group. Identification with the group is in itself therapeutic because it means belonging, which in turn means being accepted, and this feeling is one way of diluting feelings of rejection and anxiety that patients may have about not being loved. Identification with a group also produces a feeling of obligation which puts a healthy pressure on the patient to conform. From the writings of military psychiatrists we have gained new insight as to the importance to the individual of identification with a group.

How can we help patients to identify with one another? One way is by discovering their interests and organizing groups in which patients with like interests can get together. This is the basis on which recreation departments and agencies set up such activities as dramatics, choruses, writing groups, and other special-interest groups.

Another method is to utilize common experiences that patients have had in the past or are experiencing at present. We have had some interesting results with a social-club group made up of patients who are receiving insulin-coma therapy. The experience that binds these patients together is the common suffering that they are undergoing. They have been able to utilize their social group in many therapeutic ways. Patients who have been able to recognize improvement since the beginning of the treatment have encouraged others who have not yet recognized any change. Again I quote from our group records:

> "Irene said to the group, 'There's no sense in the hospital giving me those treatments.' Norma said, 'Well, they've certainly helped me.' James said, 'The food looks a lot better to me than it did before I started in to take them.' . . . Irene said, 'But these treatments are awful, I'm not going to take them any more—that's all!' Julia said, 'Listen to me. I want to tell you something. As you go along, the treatments won't be so difficult.'"

This common experience, or feeling of "being in the same boat," can be used in other settings, too. We have found that it can be used effectively, for example, on admission wards. We must remember that when a patient enters a mental hospital, he has a great readjustment to make in his habits of living. Very often a patient has had poor preparation for his entrance into the hospital, which tends to increase his hostility and suspicion. He has to accept different food and restrictions on his sex life; he has to live according to a superimposed schedule; there is a loss of privacy and individuality. Let me quote from the record that one of our leaders keeps of her work on this ward, which shows how we have been able, in a certain measure, to counteract this feeling.

> "Dorothy entered the hospital to-day and is on Ward FR 1. She has gray hair and is quite attractive. Myrtle said to the leader, 'You haven't met Dorothy yet.' The leader said she was very glad to meet Dorothy, and told her that she was from the recreation department.

"Dorothy said, 'The women have been telling me that you were coming to-day, and about the other activities, too. They said that there is something we can do both afternoon and evening nearly every day.'

"Myrtle said, 'I told her she wouldn't be lonesome once she got to know us and had gone to some of the activities with us.'

"Dorothy said, 'If I stay with you to-day, could I wear my bedroom slippers?'

"Betty said, 'Of course you can wear your slippers. Every one wears exactly what she pleases. We never change for this.'

"We started in to play a game and Arleen insisted that Dorothy get into the game. When it came time to leave the ward, the leader said that it had been nice to meet Dorothy and that she would see her again. Dorothy said, 'They are so nice to me here. I think I'll get through it all right now.'"

In a group setting, the recreational therapist finds many opportunities to help create positive attitudes toward the hospital, the therapists, and the treatments. Norma, one patient, helps by telling another, Irene, that insulin has helped her and that she recognizes this. The recreation leader carries it further by pointing out changes in others whom she has known, and assuring Irene that we really expect it will help her, too.

This example of utilization by the recreation leader of the activity on the admission ward, not only to provide a period of diversion, but to establish and strengthen bonds among the patients on the ward, illustrates how recreation work can be used to change the newly admitted patient's attitude from one of hostility and resentment to a feeling that here are people who are interested in him as an individual and who want to be helpful.

The recreation leader can also help to counteract dependency by utilizing the many opportunities to give responsibility when the patient shows indications of being able to handle it. In his relationships with other members of the group, the patient is placed in a position in which he must make decisions for himself, and must consider his needs and wishes in relation to the other members of the group. He must learn to accept responsibilities toward the other members of the group. This easing of the patient into situations in which he must manage for himself is a healthy one and assumes a great significance in hospital settings, where so much of his life is planned for the patient that if no counteracting influences were provided, he would become an extremely dependent

person with no current experience of being able to think or to plan for himself.

From the excerpt of the record of activity on the ward, we find, too, that the group setting can help to combat feelings of frustration and loss of dignity by providing opportunities for the patients to help one another. The opposite of withdrawal and preoccupation (the narcissistic level) is the experience of doing for others. Helping others can be a most satisfying experience to the patient because it makes him feel that he is of some worth and that it is still possible for him to make meaningful contributions. This compensates to a degree for the loss of dignity and the feelings of frustration and fear that are concomitant with hospitalization.

One example of how a patient can do something for another was given in the record of the admission ward, where one patient looked out for another and helped her accept the fact that she was hospitalized. In other groups we find that patients who are in better contact will help withdrawn patients who are slow in participating in any particular activity. A patient-planning group, made up of improved patients, devotes entire meetings to considering the problem of getting more patients involved in the activities, and the members spend considerable time and energy at the activities in helping the others have a good time.

Invariably in these groups, if the leader has been successful in making the patients aware of a common bond and has helped to establish meaningful interpersonal relationships, spontaneous discussion of mutual problems and concern will take place. This discussion can be an effective ventilating process. Let me quote from the group record:

> "Norma said, 'Well, now that I feel better, I wonder all the time about what I can tell the neighbors when I go home, because they'll just laugh about me being in this hospital.'
>
> "The leader said she wondered if the group could think of some ways that Norma might handle her feelings about the neighbors when she got home.
>
> "Norma said, 'Yes, can't you give me some help? They don't understand that mental hospitals are respectable. My husband thinks this is a nice place and is surprised that it is as nice as it is. I used to get so mad at them [the neighbors]. They were responsible for my getting in here in a way. No, they weren't either—I was. I get angry and I can't control my temper. That is the worst of the whole thing,' she added.
>
> "James said, 'That's a peculiar thing about us. We have all these feelings and we don't know why we have them.'"

When real problems with their anxieties and fears are brought up in the group, the leader may have to take a more aggressive rôle in leading the discussion and working through feelings for the therapeutic value inherent in the discussion. For instance, in order to tie in on a participating level those patients who already feel with Norma about this problem, the leader might ask the patients how many of them have wondered as Norma did what people in their neighborhood would say about them when they went home. In the case of those patients who still could not give any verbal response, the leader could ask them individually whether this has been bothering them, and whether Norma spoke for them, too.

Discussions of this type give the recreation leader a chance to work through these problems for additional therapeutic value. He can ask the patients how they feel about being in the hospital and what their feelings were about mental hospitals and mental patients before they became patients; what their friends used to think about these things; what they think about mental hospitals and patients now, and whether in their experience here, they have found the conditions that they had expected. The leader could point out that Norma's husband was surprised to find that the hospital is as nice as it is, and could ask whether people's attitudes toward mental hospitals aren't changing, and state that we have certain definite evidence that they are. He could ask the patients what this evidence is and supply the answers:

1. There are a great many volunteers working in mental hospitals, people who give their time to come there to work because they are interested in helping the patients. They do not get paid for their work. They come only because they want to help the patients get well and to make things as pleasant as possible for them while they are there.

2. Many organizations and individuals have shown real interest in helping improve conditions in mental hospitals.

3. There has been a lot of newspaper publicity, and many magazine articles, radio stories, movies, and novels dealing with mental illness, which have helped to interpret such illness to the general public and consequently to remove much of the stigma attached to it.

He could point out further that we are probably still quite far away from the time when every one is understanding and sympathetic, but that it helps to know that more and

more people are coming to understand that mental illness is an illness just like any other and should be regarded in the same way.

In these spontaneous discussions of problems, we find several psychotherapeutic implications. The patients feel that the leader or therapist is understanding and accepting, or the problem presented would, in all likelihood, not have been brought up. Bringing up the material, and finding that all are concerned about it, and that they feel *together* about these problems, makes relationship among the patients more secure, and releases tension by giving an opportunity for the patient to talk through these feelings and to get them "off his chest."

It has a further value, in that when patients have to face some of these problems later, they will have had some preparation for it. Some defenses will have been made, and because of this, the reaction should be less disturbing. The patient is desensitized to the problem that has previously caused great anxiety. We find that the discussion provides an opportunity, too, for the leader to do more interpretation to the group. Here the group leader or therapist recognizes his rôle as the interpreting agent of the doctor, and helps to make clear to the patient the rôle of the doctor, the aims and functions of the hospital and its various departments.

Inherent in all these experiences in group living is another therapeutic value—*i.e.*, the learning how to get along with people and the acquiring of social skills. Since many patients come to the hospital with little previous experience as members of a social group, the recreational therapist of necessity will have to give considerable help before the patient will be able to take the necessary steps to become a member of a group. The therapist will have to select the kind of group that will provide a positive experience for that patient, without disrupting the group. The ability to get along with people, to feel at ease in a group, to be able to make small talk, or to participate in commonly practiced games and activities, is something that can be achieved only through experience.

While the therapeutic values considered are most obvious for schizophrenic patients, and some of the emphasis has been on constant attack against their tendency to withdraw

from reality, most of the therapeutic benefits are applicable also to the hyperactive patients and their tendency toward "flights into reality," since most of the therapy is directed toward meeting basic human needs and satisfactions. Group activity can provide a good means of channelizing and organizing the aggression of hyperactive patients so that it becomes purposeful, and the patients get satisfactions in terms of achievement. Pressures by other members of the group help the overactive individual to keep within certain bounds and to follow through on projects.

So far we have shown how we can help the patient, through his guided group experiences, to get emotional support and reassurance from the recreational therapist and from members of the group; how we can dilute his feelings of anxiety and rejection by helping him identify with the group; overcome his hostility and suspicion and develop positive feelings toward the hospital and the therapy; counteract his dependency by giving him opportunities to assume responsibility; combat feelings of frustration and loss of dignity by providing opportunities for him to help others; provide opportunities for ventilation and desensitization; give him the positive experience of functioning in a group setting and learning social skills, and constantly ease him from his phantasy life into one of reality. The group provides real-life situations, with opportunities for the patient to change from his absorption with his own problems to one of awareness of other people's, to move from considering problems as exclusively his own to sharing them with others.

Effective use of the therapeutic possibilities in work with patient recreation groups is dependent on two factors in addition to recreation skills: (1) the leader's understanding of group dynamics and individual behavior and his rôle in relationship to the individuals (this would indicate a person trained in a graduate professional school of social work); and (2) the leader's ability to coöperate and to plan with the other members of the treatment team (*i.e.*, the psychiatrist, the psychiatric case-worker, the nurse, and others in direct working relationship with the patient) and the integration of the group-work program with the total treatment plan for the individual patient.

BOOK REVIEWS

PSYCHOSOCIAL MEDICINE: A STUDY OF THE SICK SOCIETY. By James L. Halliday, M.D. New York: W. W. Norton and Company, 1948. 278 p.

This is indeed an important, a thought-provoking book, with implications that aim at the very core of our survival. It integrates our contemporary knowledge, and while its approach is through a specialty, it brings home the limitation of any specialty unless it is integrated into the whole approach.

Psychosomatic medicine, which is the trigger for psychosocial medicine and ultimately bio-politics, is based on the premise that man is the end result of forces that envelop him from without and urge him forward from within. The creative implications of growth are becoming more and more disciplined by the machine, so that the flow of life is dammed back on itself, and creates havoc when it is dammed back upon the individual, equally creating destruction when it breaks the dam and attacks the social scene.

Dr. Halliday has had the unique experience of working with society as a public-health administrator, among his other activities. As public-health administrator, public health meant something far beyond physical health, and also something far beyond mental health. It carried with it good political soundness as well. The interesting parallelism between a sick society and a sick individual may perhaps be too much for some readers to accept. The reviewer, however, feels that the analogy is an apt one, which can be utilized constructively.

The author cuts across many fields of thought. Some are, of course, mentioned only casually. As a matter of fact, there are so many aspects implied in the rehabilitation of society that if we were to utilize the concept that all knowledge in all fields is deeply interrelated and must be applied, we would be appreciating some of his implications. As one reads, one is struck by the strange coincidence that Toynbee should be contemporarily of such great interest, particularly in this country, for his description of the cycles of civilization and Halliday's psychodynamics and bio-political evaluations can and should be tied-in together.

The dignity of labor and of craftsmanship has been broken down through science. The assembly line is a monstrous conception, for it gives birth to abundance which is not available unless there is war, and thus enables the populace to experience universal "prosperity" only when threatened with annihilation. What irony is

implied in this! Frustration begets aggression, and aggression in the hands of unprincipled leadership has dragged civilization into rubble. Wherefrom comes the good leader, and how does he function? The implications of the misuse of production and the tempo of production by evil leaders, by tyrants, is clarified. It seems as if each social structure, like the human organism, has inherent in it the seeds of integration or of disease. What value has physical health, if physical health has no creative outlet? What function to society if there are no outlets for the average human being's need to belong and to create? The "repression of the life stream" in groups leads to a conglomeration of manifestations which fall into our current concept of psychosomatic disturbances. This is enumerated in detail and emphasis is placed on the attenuation of the fundamental biological creative urge, as evidenced by the falling birth rate among those who are most qualified to procreate leaders. It is a concept to which Ortega y Gasset called attention, a decade ago.

Halliday analyzes the sick body politic in terms of a sick Great Britain, and uses for his laboratory demonstration the mining industry of that great country. The data available are spread between the contents and the appendix, which is an integral and important part of his evidence. Naturally, the hopeful contribution is summed up in the chapter, *Problems of Reintegration,* which basically means using the indices of psychosomatic disease as evidence of a sick society and applying the knowledge gained from our work with individuals to a rebuilding of society. This implies a much broader concept than that of economic security, which is only one of many phases in the meeting of man's needs.

The whole educational contribution must be revamped in terms of the fundamental values by which man lives, the creation of some form of faith that will carry society through crises not necessarily precipitated by war alone, and the education of our leaders along the lines of socio-biology, a term which takes in the fundamental cognizance that each individual needs a place in society that will make his ego secure. Working with others coöperatively and not competitively will help to accomplish this, making it possible for each individual to function according to his God-given endowment.

If our future is invested in leaders who can rise above petty group aggrandizements, and who can see the major problem in terms of the total welfare, there would be hope for society. Bio-sociology is one of the instruments. Society, like the human organism, should be a well-balanced, functioning unit, with no cells, lawless and malignant, to threaten degeneration and jeopardize existence itself.

EDWARD LISS.

New York City.

HUMAN RELATIONS IN THE CLASSROOM: COURSE I. By H. Edmund Bullis and Emily E. O'Malley. Wilmington, Delaware: Hambleton Company, 1947. 222 p.

This is a publication by the Delaware State Society for Mental Hygiene. It represents the first of a series, setting forth the principles and methods underlying Bullis' pioneer work in the teaching of human relations in school classrooms. Of the thirty-six chapters, thirty consist of lesson plans, prepared for the seventh-grade level, successfully used with grades 6 to 10, but best adapted, according to the authors, to grades 6 and 7. The other chapters deal with the technique and its purposes, with particular emphasis on mental-hygiene goals and aspirations. There is a pleasing introduction by Howard Whitman.

The senior author, Colonel H. Edmund Bullis, is a peculiar type of lay genius. It is easy to have faith, even confidence, in what he is doing, yet it is not easy to define. He has been stimulated by professional leaders. His heart has insisted on a practical program that pushes ahead, even when his professional colleagues, though hopeful, are uncertain. This indomitable characteristic has stimulated his professionally conservative colleagues, who, in turn, have admired his pioneer efforts and found them good. Teachers, including his obviously able co-author, have been profoundly influenced by his realistic approach to an idealistic mission—giving children an opportunity to face the essential problems of living. It is a safe guess that the children participating in his program are challenged as they like to be challenged, and are stronger emotionally because of their partnership with him.

Scientifically (or artistically) this is a non-directive age within the fields of psychotherapy, parent education, teaching—even (we hope) economics, industrial relations, and international affairs. Non-direction is more than a recognition of the inadequacies of our old "thou shalt's" and "thou shalt not's." It is by no means a denial of our time-honored moral code—even though it may be a drastic criticism of our methods of transmitting that which is fine in tradition to the on-coming generation. Nor is it merely an affirmation of our faith in human nature. It is, however, a technique of revealing the constructive yearnings of people, and of giving people a chance to be constructive—personally and in the interests of the common good. Bullis has pioneered in giving children a chance to contribute to their own well-being, and to the clarification of the method whereby personal and social problems may be tackled, without the usual amount of institutional restriction.

The reviewer would urge the reader to be tolerant of the superficial

weaknesses of this book—its obviously hasty preparation, its lack of scientific dignity and precision. There is a more fundamental challenge in its purport. We have given the rising generation plenty of opportunity to examine the abstract logic of our cultural progress—its tools of mathematics and communication. Bullis suggests that we give them scope in examining our ways of living. On the former, we (the past) lead, and invite their contribution to the continuation of progress. On the latter, we ask them to scrutinize our limitations, and to pioneer, creatively, in the reformulation of what "living" involves.

The technique appears to be right—in the right direction. The implications of the technique are revolutionary. Science will have to direct this technique. But without question the challenge it presents is worthy of our most sincere appreciation and partnership.

The book is not a great book. Its implications probably are great. Certainly, the technique it reveals is very important.

W. Line.

University of Toronto.

Intellectual Status at Maturity As a Criterion for Selecting Items in Pre-School Tests. By Katharine M. Maurer. Minneapolis: The University of Minnesota Press, 1946. 166 p.

The true value of an intelligence test lies not only in its usefulness in describing a child's intelligence at the time the test is given, but in its ability to predict what one's level of intelligence will be in adulthood. Many studies exist that demonstrate consistent results between tests repeated on the same child when the first test was given after five years of age. In fact, when retested, half of all school children vary not more than five points upward or downward from the intelligence quotient (I.Q.) which they scored when they took their first intelligence test.

Available tests that can be given in infancy or at the ages from two to five are much less accurate in prediction than those for children of school age. The results of tests on young children are not good enough to make future plans for the individual child, Dr. Maurer says. In this comprehensive study, she attempts to evaluate the 448 test items included in Forms A and B of the Minnesota pre-school scale in terms of the usefulness of each item in predicting adult intellectual status.

Originally, intelligence tests were devised to segregate the dull from the bright children; particularly, to separate those who were seriously retarded mentally from those who could benefit from the school learning situation. A. Binet, a pioneer in this field, constructed a series of tests on which it was found that children earned scores

that compared favorably with teachers' ratings, achievement in school, and later intellectual status. Many revisions have been made of the Binet tests, and all bear evidence of a certain core of stability in mental function that is measurable at any age. The question whether such tests predict future intellectual status depends on whether the items measure mental qualities that remain stable and that increase in scope with age. Binet described three major characteristics of intelligent behavior: (1) the ability to take and maintain a given mental set; (2) the capacity to make adaptations for the purpose of attaining a desired end; and (3) the power of auto-criticism.

In order to determine whether tests given in the pre-school years have been of value in predicting adult status, or what Dr. Maurer calls "terminal status," it is necessary to work with test records of a large number of cases over a period of time. The test records at the University of Minnesota as far back as 1926 were examined. A list was made of all those who had reached the age of sixteen or over by June, 1942, and who had taken at least one Minnesota pre-school intelligence test before the age of six years.

Of 1,091 names on the list, it was possible to make contact with the families of 437 cases. Some of these were in the armed services or away at school, and some were unwilling to give the time to coöperate in this research project. Two hundred and twenty-six—52 per cent of the 437 cases—replied favorably. They came in twos and threes or in groups up to fifteen, and it took three months to complete the retesting of all of them.

To give an idea why such a comprehensive piece of work on this subject was justified, the reader should consider the problem of placement agencies who are faced with the need to match children for adoption with suitable adoptive parents. Dull children placed with intelligent parents may become maladjusted because of misguided attempts on the part of the parents to push the children beyond their intellectual capacity. If, on the other hand, bright children are placed with parents less intelligent than themselves, the limitations of the parents may hinder the optimum development of the children they adopt. Agencies are dependent upon the scores of intelligence tests given to infants and young children, as a guide to their probable intellectual capacity. If the tests are faulty in predictive value, the agencies cannot place children with the most suitable adoptive parents.

The 226 young men and women of from sixteen and a half to twenty-two years of age who were willing to be retested were given the Wells revision of the army Alpha test (a group intelligence test with some slight modifications from the original army Alpha test), an interests questionnaire, the American Council of Education psychological examination, and the coöperative English tests. The last two tests

proved to be too limited in scope to be useful measures of terminal status. The Alpha score was considered to give a good measure, as it is a test standardized on the general population and not limited to any special group.

The interests questionnaire yielded information as to years of schooling, but as some individuals had not yet finished their education, this section of the questionnaire was not a good measure of terminal status. It was found, however, that those with raw scores of 100 and under on the Alpha reported leisure-time activities and interests of a markedly limited variety (often not more than movies, dancing, and visiting friends), whereas those with much higher Alpha scores reported interests that would be expected of a highly gifted group, such as playing all kinds of musical instrument, attending concerts, camping, creative writing, playing chess, and many other diversified complex voluntary activities.

The retest scores were compared with the intelligence tests given the same subjects during their pre-school years. All of the items in the early and later tests were analysed to determine which pre-school test items had helped to predict the terminal status of each individual. Many items were not predictive. Either they were too easy, so that the children could answer automatically as taught by parents, like simple commands ("Now put the ball on the table."), or naming parts of the body ("Show me the dollie's eyes. Put your finger on her eyes."); or they measured varying experience rather than innate intelligence ("What should you do if you should find that your house is on fire?" or, "What should you do if you are going some place and miss the trolley car?"); or they demanded greater muscular coördination than the child had, like copying drawings.

Even the use of speech in the young child may not be a true measure of intelligence, as some children are more talkative than others, just as adults differ in this respect. Dr. Maurer points out that this may be a personality difference which shows even in young children, rather than a difference in intelligence.

The best thing that could be said for the non-predictive items was that when subjected to statistical analysis, it was found that apparently they contributed nothing to the scales, but neither do they subtract anything from the predictive value of the scales. Dr. Maurer classifies them as "dead wood" and suggests that they be removed to save time or be replaced with items more predictive.

As for the items now in the Minnesota pre-school scales which proved to be predictive, it was found that certain tests, like imitative drawing or building a simple block tower to imitate that built by the examiner, required a minimum of motor skill and were tests of intellectual function. Items like giving definitions, vocabulary, absurdities,

and word opposites are found in tests at all ages, so it is not surprising that they are predictive when used at the pre-school level. However, the digit-span test, a good item even at adult levels, also proved predictive at early levels ("Now I'm going to see how well you can say numbers. Say, 'Two.' Now say, 'Eight, six,' " and so on).

Other good predictive non-verbal tests are the Knox cube imitation (in which the child is asked to touch a series of blocks in the same sequence as the examiner did before him), form discrimination, tracing forms, solving picture puzzles, and naming the part missing in mutilated pictures. Predictive verbal tests in addition to those named above included response to pictures, naming colors, recognizing objects in incomplete pictures, and understanding directions.

To summarize, Dr. Maurer found that the use of "terminal status," the technique described in this study, is a good method to determine which items in pre-school intelligence tests are most useful in predicting adult intellectual status. The types of test item that should be eliminated are those that make heavy demands on motor or language skills, those that are affected by varying experience, and those that have faulty directions for administration and scoring.

Striking evidence of a constant core of mental functioning appeared in all phases of this study. A number of tests were found to be as good at the adult level as at the pre-school levels of four or five years. Further analysis of individual test items is needed to make pre-school tests more valid and more predictive for practical purposes. A bibliography of 99 references, an author index, and a subject index are included in the monograph, as well as complete directions for administrating and scoring the Minnesota pre-school scales.

A number of subjects wished to discuss their test results. Some felt that their achievement did not come up to that indicated by their intelligence-test score. This reviewer particularly liked Dr. Maurer's apt description of the useful, but limited significance of an intelligence-test score when she said "... in each instance they were reminded that personality traits, interests, physical energy, special abilities, and work habits, as well as general intellectual status, affect achievement."

HELEN OEXLE PIERCE.

Hartford, Connecticut.

CURRENT TRENDS IN PSYCHOLOGY. By Wayne Dennis, *et al.* Pittsburgh: University of Pittsburgh Press, 1947. 225 p.

In the early part of March, 1947, under the auspices of the Department of Psychology of the College of the University of Pittsburgh, there was given a series of eight lectures formulated with reference to current trends in the several fields individually represented by each of the eight lectures. Each lecturer was a recognized authority in

the field that he discussed. The book under review is a recording of the lectures, and for all except *Psychology as a Profession, Personnel Psychology,* and *Human Engineering,* bibliographies have been appended.

Dr. Wayne Dennis outlines the present status of psychology as a profession and presents his views on the prerequisites that he feels a person should have in order to be designated a trained psychologist. His suggestion is that the only practicable way to define a trained psychologist is by denoting him as a person who has the Ph.D. degree in psychology or who is a fellow of the American Psychological Association. Although he recognizes that there are very well qualified people who do not meet these requirements, he seems to feel that there is a real need for drawing a line and that his suggested demarcation is best, even if it is occasionally unjust.

The question might be raised whether it is not possible to work with the problem with a view to obviating the anticipated injustices to some psychological practitioners and to the populations served by these well-qualified persons. The apparent rigidity of Dr. Dennis' stand will undoubtedly be a cause for concern to many persons, as he himself seems to anticipate.

To the reviewer, it seems that the lecturer has labored the case for the Ph.D. too much, though it cannot be gainsaid that one who is to engage in professional practice should have adequate training for his profession before he starts work.

There follows an excellent chapter by Dr. Skinner on experimental psychology. In carefully defining what could be and logically should be the methods and aims of the experimentalist, and by showing the relationship of the work of the experimental psychologist to the other fields, he gives a stimulating picture that should encourage competent scientists to devote their time and energies to experimental psychological researches, to the inestimable benefit of mankind.

Trends in child psychology are ably described and evaluated by Dr. Robert R. Sears. In child psychology, development is currently in progress beyond the stage of typography and norms toward the stage that treats of the child's molar behavior in his social setting. Observational sampling and projective techniques have been found useful tools in speeding this progress.

Clinical psychology is represented by Dr. E. Lowell Kelly. He reviews briefly the history of the clinical psychologist from the time, less than ten years ago, when he was a technician, grinding out I. Q.'s day after day for a salary of a few hundred dollars a year plus maintenance, to the present time, when Civil Service announcements list minimum salaries above $4,000. For the present-day clinical psychologist, the finding of the I. Q. constitutes a very small item

of his professional duties. Specifically, his duties include diagnosis and treatment of maladjusted individuals and research on neuropsychiatric problems. The factors that have contributed to this rise in professional status are described and evaluated. Much of Dr. Kelly's discussion is oriented around the special program of the Veterans Administration and, it would appear, rightly so, since this program has been such an important factor in the present status of the clinical psychologist.

The psychologist is seen as a full-fledged member of the neuropsychiatric clinic team, consisting of psychiatrist, psychologist, and social worker. The psychologist directly participates in diagnostic and treatment work according to the requirements of the specific problem that is presenting itself. In addition to this, he should assume responsibility for sorely needed research work.

Dr. Carl R. Rogers clearly indicates his position in the controversial field of psychotherapy and describes and evaluates both convergent and divergent trends in this field. This paper is well worth reading regardless of the "school" of psychotherapy with which one might wish to identify one's self. There is a 56-item bibliography.

Dr. John C. Flanagan's contribution is the chapter on personnel psychology. This is followed by Dr. Clifford T. Morgan's paper on human engineering. In their presentations, they follow the same general scheme of their predecessors. Careful consideration is given to definitions and there are historical reviews. Dr. Flanagan suggests a twenty-year program, pointing out those areas that are most promising for future research. Dr. Morgan shows nicely how pure, fundamental, and applied researches can be integrated in human-engineering work. Some concrete illustrations add to the interest value of the material.

In the final chapter the sample interview survey is described, and the special techniques required in its use as a fundamental research tool of the social sciences are evaluated.

Dr. Likert relates in some detail first-hand experiences in sample-interview-survey work. The reader can hardly help absorbing some of his enthusiastic interest.

EDWARD S. KIP.

Bureau of Mental Hygiene, Hartford, Connecticut.

WARRIORS WITHOUT WEAPONS. By Gordon MacGregor, with the collaboration of Royal B. Hassrick and William E. Henry. Chicago: University of Chicago Press, 1946. 228 p.

This book depicts the status of a dispossessed people, deprived of religious liberty, of their own form of government, and of their accustomed means of livelihood; and the economic and psychological effects

of substituting rations and cash subsidies, even though these were secured by treaty agreements, in place of a normal way of life. It is especially pertinent in view of reports from European areas that the same effects are being observed where the people are looking to Uncle Sam to play fairy godmother.

The book depicts what the right kind of help can do for a dismayed people by describing the results of a better organized program in recent years. It is discouraging to learn that, since the appearance of the book, the cutting down of appropriations for carrying out a constructive program of rehabilitation has interrupted the reconstruction of a normal way of life for these, our closest neighbors and most loyal fellow citizens.

> "Life without purpose, demoralization of the people, failing will to live, constant repression of energy, occupation of the men abruptly vanished—such phrases all might aptly describe the hopeless, starving people of Greece or of France during the days of Nazi occupation. But this is not their story. Instead, it is the story of a group of American Indian citizens whose lives were disrupted and whose cultural and economic patterns were ruthlessly destroyed . . . not by totalitarian armies, but by the 'civilization' of their white fellow Americans.
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> "About two hundred and fifty years ago the Sioux Indians came from the woodlands onto the plains and adapted themselves to hunting buffalo. Since that time, they have constantly had to make many adjustments to new environments and new ways of life. One hundred years ago, the white men encroached on their territory and their food supply, causing the series of struggles that ended in 1869 with the removal of the Sioux to reservations. Thus, for less than a hundred years, these Indians have been traveling the road leading to the white man's civilization.
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> "The road has been rough, and the thirty thousand 'subject peoples' who have trod it are not only warriors without weapons—the majority of them are warriors without will. Defeat followed defeat, and finally the greatest single catastrophe occurred in 1916–1917 with the sale of their cattle and the loss of grazing land. This meant another change in economy and way of life, and the effects are still apparent in the amount of government dependency among the Indians. The story of this fall is a gloomy one indeed; but, when it is described, as in this book, from the standpoint of what that decline has meant to American Indian children, the outlook becomes a problem of great concern."
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> "This volume is the second of five integrative studies of Indian personality produced as part of the Indian Education Research Project, which was undertaken jointly by the Committee on Human Development of the University of Chicago and the United States Office of Indian Affairs. The objective of this project was to investigate, analyze, and compare the development of personality in the Sioux, Hopi, Navaho, Papago, and Zuni tribes in the context of the total environmental setting—socio-cultural, geographical, and historical—for implications in regard to Indian Service administration. . . . Since its inception in 1941, the research has progressed experimentally, under the supervision of the research committee of the University of Chicago, through the coöperative efforts of a large staff

drawn from several disciplines—chiefly anthropology, sociology, psychology, psychiatry, medicine, linguistics, education, and administration."

"The first field problem was to investigate the development of the personalities of a sample of about a thousand children, six to eighteen years old, selected by age groups so as to represent two or more communities in each of the tribes, in the context of the total environmental setting. . . . The personalities and life-histories of these children were studied by means of a battery of psychological tests of both the projective and performance types, supplemented by interviews with parents, teachers, and other community members and by medical examinations."

"The special interest of this study of personality has been in the effect of cultural change and present social conditions upon the Sioux. The nature of this change and the resultant disorganization of the society have profoundly affected the Sioux people and may fairly be assumed to be major determinants in their present personality adjustments. . . . In presenting the environment and the cultural changes and their effects upon the personalities of Pine Ridge children, the material has been organized on the following basis: Part I describes Sioux society in the past and at present, giving the historical and economic bases of reservation society to-day, the values and attitudes which characterized the pre-reservation culture, and those which it has retained or acquired in the last seventy-five years. Part II describes briefly how the Sioux child grows up. Against this background of the society as it has been and is to-day are set, in Part III, the personalities of the children who will be the adult Sioux of to-morrow. Conclusions follow in Part IV."

"Three aspects of the dramatic period of change from Indian to white culture . . . are important to note: first, the suppression of Indian custom and authority; second, the education of the children in the techniques of white life; and, third, agency and other white pressures upon the adults to adopt white ways of making a livelihood."

It should be pointed out that the change to "white culture" involved the extravagant waste of natural resources in place of the Indian habit of conservation, and the experience of seeing children slapped, whipped, and subjected to other physical punishment in schools in place of the Indian methods of training which are now making slow progress among educators, under the name of "progressive education."

When measured by a non-verbal intelligence scale, 166 Sioux children earned an average I. Q. of 101.1 in one community and 102.6 in another. When examined by physicians, only one in five was rated as having generally good health, four out of every ten children appearing to be undernourished. This is understandable in view of the fact that in 1942 the mean family income on Pine Ridge was $457.90. "The general poor health and under-nutrition among the children may affect their personalities, chronic hunger being reflected in temper and behavior."

The detailed study of ten individual Sioux children is revealing. John Collier, former Commissioner of Indian Affairs, in his *Indians*

of the Americas, has provided an excellent background for this intensive study of personality development of the children of one Sioux reservation.

Psychologists are asking for a detailed study of children in the European war areas who have come through the experiences of war, displacement, starvation, and post-war life under military control. Such a study may be desirable, but is not as necessary as it might be without this book, which reports the effects of this kind of experience upon successive generations.

Warriors Without Weapons is remarkable for its objective presentation of the details of the hardships of a group of displaced persons subjected to the pressures of an alien culture. At no point is there apparent any identification either with the oppressors or with the oppressed.

GRACE ARTHUR.

St. Paul, Minnesota.

CHILDREN OF THE PEOPLE. THE NAVAHO INDIVIDUAL AND HIS DEVELOPMENT. By Dorothea Leighton and Clyde Kluckhohn. Cambridge, Mass.: Harvard University Press, 1947. 277 p.

This is the second and last volume of Dr. Leighton's and Professor Kluckhohn's joint study of the Navaho, made on behalf of the Indian Education Research Project. The second volume fully matches the high standards of the first.[1]

The book opens with a brief presentation of the life and world of Betsy, a Navaho girl eleven years of age, a full analysis of whose psychological tests is to be found in Appendix II. Additional information about Betsy is to be found in Chapter IX.

The first part of the volume is devoted to a study of the Navaho life cycle.

Chapter I describes the first six years of the Navaho's life. Accurate, informative, carefully thought through, and well presented, the material gathered by Drs. Leighton and Kluckhohn on the birth, nursing, weaning, toilet training, and so on of the Navaho infant and toddler is altogether exemplary and can be profitably utilized by all students of human behavior, whether their orientation is culture-historical or psychoanalytic.

Chapter II deals with later childhood. It was a great satisfaction to the reviewer that Drs. Leighton and Kluckhohn's findings concerning the relationship between social structure and libidinal

[1] *The Navaho,* by Dorothea Leighton and Clyde Kluckhohn. Cambridge, Mass.: Harvard University Press, 1946. Reviewed by G. Devereux in MENTAL HYGIENE: Vol. 32, pp. 114–16, January 1948.

economy among the Navaho substantiate point by point his own general theories on this subject, as well as his special applications of this theory to the Mohave Indians.[1] The presentation of data pertaining to discipline and training, as well as to acculturation, is unusually thorough and sound. On the other hand, the problem of sexuality receives only scanty attention, and we find little or nothing in this book that can help us to decide whether or not the latency period, which many of us believe to be absent in most primitive societies, is present or absent among the Navaho. Masturbation and pre-pubertal sex behavior are likewise slighted.

Chapter III contains a fine study of adult life. Though brief, it provides us with a comprehensive view of adult pursuits and modes of behavior, with the exception of genital sexuality, which, once more, is dealt with rather sketchily.

Chapter IV describes the dynamics of human relations, and puts flesh on the skeleton of dry analyses of kinship systems. It also contains a careful analysis of certain Navaho character traits, such as curiosity, shame, shyness, withdrawal, space-time vagueness, emotional volatility, realism-unrealism, imagination, and so on. This chapter is highly rewarding to the anthropologist, as well as to the psychologist.

The second part of the book presents data pertaining to the testing of Navaho children. Chapter V describes the testing procedure, and analyzes the distinctive features of the socio-economical setting of the districts of Shiprock, Ramah, and Navaho Mountain, in which the testing was done. Since the Navaho tribe is a very large one, the authors have wisely refrained from sweeping generalization about data obtained in widely different settings.

Chapter VI presents the over-all results of physical and mental tests administered to Navaho children. To judge by the Arthur and Goodenough tests, there are, for the three tested groups taken as a whole, conspicuously fewer "very superior" and "superior," and slightly fewer "average" and "dull-normal" children among the Navaho than among the whites. The total score of the Navaho was pulled down by the poor performance of the children of the Ramah district, since the group of Shiprock children contains more "average" individuals than do white samples.

There were also serious discrepancies between the I.Q.'s yielded by the Arthur and by the Goodenough tests; and the I.Q.'s inferred from thematic apperception tests and Rorschach tests did not always approximate those yielded by intelligence tests. These discrepancies

[1] Presented in articles in the *Psychoanalytic Review*, the *Psychoanalytic Quarterly*, *Character and Personality*, etc.

are discussed in some detail. The possibility that intelligence tests are of relatively little value in cross-cultural studies is, however, barely mentioned.

Chapter VII discusses the data obtained through the Stewart emotional-response test and the Bavelas moral-ideology test. This chapter is a very valuable one, since the findings suggest that tests of this type can be used fruitfully in cross-cultural studies. The results fully confirm the thoughtful earlier generalizations of such expert students of the Navaho as Kluckhohn, the Leightons, W. W. Hill, and others.

Chapter VIII presents the results of the thematic apperception tests and Rorschach tests and further confirms the findings of other scholars that projective tests are of great value in cross-cultural studies. Chapter IX contains several brief, but meaty life histories, and some very sensible characterizations of a number of individual children.

In conclusion, the authors attempt to summarize the value of the study for a constructive planning of the future of the Navaho. The reviewer feels that they have been far too modest in their claims. Their findings should help an enlightened administration to enable the Navaho to build for themselves a future rich in tribal and personal rewards and satisfactions.

Appendix I contains sample responses to various tests, and Appendix II gives a full account of Betsy's tests and of their results.

The publisher's blurb—"Probably no anthropological study has ever been based upon so many years of field-work by so many different persons"—is, if anything, an understatement, and soft-pedals the fact that the person responsible for this happy situation is Professor Kluckhohn, who for many years has been the driving force behind almost every study of the Navaho.

The reviewer has not attempted to condense this meaty publication into a few paragraphs, since its two volumes are already a synthesis of years of field work, and of an immense published and unpublished literature written by many reputable scholars. The industry, good sense, and creative thinking of the authors deserve the admiration and gratitude of all students of human behavior. These two volumes are a radical departure from the traditional anthropological monograph, systematically exploring the conscious and pre-conscious world and life of an interesting tribe.

In view of the extraordinarily high quality of this book, it is a particularly distasteful duty of the reviewer to point out the relative neglect of the deeper layers of the Navaho Indian's psyche. Psychoanalysis is barely mentioned. The terms, "Œdipus complex," "introjection," "super-ego" and so on do not seem to appear anywhere;

dream life is practically ignored; and the processes of the unconscious are consistently slighted in favor of an admittedly brilliant and novel approach to the conscious and pre-conscious world, and to attitudes subject to formal testing.

This may, perhaps, be the result of a reaction against certain excesses committed by psychoanalytic armchair anthropologists, since the reviewer knows that the omission is not due to lack of familiarity with psychoanalysis, or with the anthropological applications of that discipline, on the part of the authors. Perhaps their intention was to remind us of something that all of us know, and that most of us pretty consistently ignore, in our psychoanalytic interpretations of primitive data—the importance of reality, of the reality principle and of ego-functions.

If this inference is correct, one cannot but feel that the authors would have considerably strengthened their warning had they systematically considered side by side, and had they blended into a novel functional whole, the conscious and the unconscious, social conflict and unconscious conflict, the synthesizing functions of the ego and the forces of repression, and so on. There is no doubt that they were well qualified for such a pioneering task. One cannot but hope that in due time they will present us with a third volume, devoted to a depth-psychological analysis of the dynamics of Navaho behavior. In making this demand, the reviewer feels somewhat in the position of one who, upon being presented with a Cadillac station wagon, complains that he does not at the same time receive a Rolls Royce limousine. His attitude is, however, justified by the ancient Arab proverb: "Allah is great, and gave man a mouth to ask with."

GEORGE DEVEREUX.

TEXTBOOK FOR PSYCHIATRIC ATTENDANTS. By Laura W. Fitzsimmons. New York: The Macmillan Company, 1947. 332 p.

In an endeavor to lessen the disadvantages of war conditions in mental hospitals, The American Psychiatric Association, through its Committee on Nursing, recommended a program of classes for attendants that would be uniform throughout the country. To implement the program, Mrs. Fitzsimmons, while she was nurse consultant for the American Psychiatric Association, prepared a manual for training attendants in mental hospitals.

The book under review, *Textbook for Psychiatric Attendants,* is a supplement to the manual and is intended to be used by attendants. Its value to them will depend upon the teaching program that underlies its use. Mrs. Fitzsimmons is well qualified by preparation, experience, and interest to prepare such a text.

Dr. Charles P. Fitzpatrick was chairman of the Committee on Nursing of the American Psychiatric Association during the preparation of the book. In a foreword, he states that the committee felt "that if a more or less uniform preparation could be given [to attendants] many advantages would follow." He mentions, among other items, that "administrative officers would be greatly aided if they knew fairly definitely the degree of training the prospective employee has received." Again, "a course of training in normal times would attract a higher type of employee and could serve as a sieve in screening out the less desirable." These are worthy objectives and whatever measures contribute to their attainment merit consideration.

Textbook for Psychiatric Attendants has material that should interest and enlighten the reader. Included are a summarized history of psychiatric nursing, attitudes appropriate for psychiatric attendants, and methods of performing certain procedures. Ultimately patients should benefit by the improved care they receive as a result of the education provided for ward attendants. There are indications that the book may have been assembled hastily or that the editing of some of the contributions was scanty; in a second edition such matters can be corrected. Credit is given to Mental Hygiene Leaflets for permission to include material on some popular misconceptions, and the section on occupational therapy credits the chief occupational therapist at St. Elizabeths Hospital with the material included on that subject.

Loose-leaf binding would be a convenience in using procedure books and ward manuals.

MARY E. CORCORAN.
United States Public Health Service, Washington, D. C.

SOME NOTES ON THE PSYCHOLOGY OF PIERRE JANET. By Elton Mayo. Boston: Harvard University Press, 1948. 126 p.

This book requires time for reflective thinking if the reader is not to be lost in the logic that leads to the development of a psychological system based upon the clinical observations of Pierre Janet and the author.

Obsessive thinking and feeling are used as the medium for developing the frame of reference that is to aid one in understanding the complexity of human nature. Observations on hysteria precede, as a means of clarification. The author points out that mental hygiene began as an inquiry into hypnosis and hysteria.

Janet's observations of hysteria led him to the conclusion that the true hysteric is characterized by a so-called double or alternating personality, resulting in dissociation. This dissociation includes both a disjunction between parts of the sensory field and between systems

of acquired response. Case histories illustrate how the dissociation of hysteria is identical with or resembles hypnosis. It was the discovery of this alternating personality that led Janet to postulate a psychology of the normal mind.

Janet assumed that the capacity of an organism to maintain its full complexity of balanced relationship within itself and with the world, and the capacity of the organism to complicate its responses, must be considered essential to a well-integrated personality. It is then made clear that the integral response must rest upon reflex, habitual skill, and attentive effort. The implications of these assumptions for industrial workers are that "practice makes perfect, not because of mere repetition, but because 'awkwardness, error, and round-about ways' are not repeated; they are eliminated. Habit is not repetition . . . it is an acquired integral response to a many-faceted situation."

The author then presents Janet's observations on the nature of obsession: "As the incidence of hysteria diminishes, the incidence of obsession rises. Obsessive thinking is highest between the ages of twenty and forty. A certain measure of intelligence and education characterize those who develop this disability. Time is required for the reconstitution of the obsessive's habits of thinking and living."

In describing the obsessive, Janet comments, "He is embarrassed, uncomfortable, he has trouble in expressing himself; but in reality he knows very well what is tormenting him. It is from the patient himself that we learn the content of the obsession. . . . Obsessive crises have no defined beginning and no definite end. Many patients claim to be afflicted with sexual inversion . . . these cases are simply manifesting a common symptom of obsession . . . the dread they are possessed by a compulsion to crime or irregularity. In the obsessive the determinant is the inner reasoning and emotional preoccupation. They drive themselves to consider and decide upon every minor thought and act as if a moral decision of immense importance were involved. Obsessive preoccupation seems to predispose the individual to the development of elaborate rituals."

Utilizing the frame of reference for the integrated personality, Janet then proceeds to determine the etiology of obsessive thinking and feeling. "The crises of obsessive thinking and feeling, the moments when the mental distress is exasperated, relate themselves to some action in the present which the patient cannot perform. . . . There is an actual incapacity for adequate action . . . the patient himself is aware of the inadequacy and gives expression to it."

It is then made clear that social actions are the most complex and make the heaviest demands upon the resources of the individual. "It is the social aspect of reality that obsessives cannot adapt them-

selves to. The obsessive is a lonely individual keenly anxious for human friendship, but utterly unable to achieve it." The idea that "the tension necessary to adequate performance cannot be achieved if any of the minor contributory activities are missing," is then developed at some length.

The crux of the entire course of logical thinking may now be found in the comment by Janet "that the best indication or symptom of normality is the ability . . . of turning attention, immediately and easily, to a topic or subject presented for consideration." The obsessive cannot do this. Janet then points out that it is by reflection that we give unity to our thinking. The obsessive cannot do this.

All of which brings the author to the final conclusion that there are three implications that must be understood by all students of society. The first two involve the complexity of the attentive act and the relationship of action and reflection. The third involves the ability to recognize the emergence of obsessive thinking. "The appearance of such symptoms will warn him [the student] that there is some irksome constraint or feeling of insecurity imposed upon the individual or group studied by the general conditions of the surroundings." If this constraint or insecurity is not understood, the problem will remain unsolved. There must also be a basic understanding that in every instance there is an organic disability of some kind—that is, unbalance, infection, defect, or pathology. Such people are frightened people and are always in need of reassurance. But the assurance must be directed at the focus of need. Arriving at the basis of the need will require careful analysis, not only of the individual involved, but of the social situation in which he lives. Treatment must then be directed not only toward the individual, but in many instances toward the society itself.

Roy F. Street.

Grand Rapids, Michigan.

Studies of Compulsive Drinkers. Edited by Jane F. Cushman, M.D., and Carney Landis. New Haven, Connecticut: Hillhouse Press, 1946. 90 p.

This monograph is made up of two parts. Part I, *Case Histories,* is by Herman Wortis, M.D., and Leonard R. Sillman, M.D.; and Part II, *Psychological Test Results,* by Florence Halpern, M.D. It gives the results of psychiatric, psychological, and social studies of fifty compulsive drinkers, presented in such a way as to conceal the identity of the individual cases.

The histories of eighteen well-selected cases are given and the entire material is compared with normal controls. Most of the

alcoholics were from the upper social and economic levels and had high educational achievements.

No evidence was found that inebriate behavior could be related directly to any single event or to any single relationship in the life histories of these people, but it is stated that, on the basis of "psychological test results, the alcoholic appears to be a poorly adjusted, unstable, restless individual. Unlike many poorly integrated people, he does not withdraw in the face of disturbing situations" or "resort to the usual adjustive or neurotic forms of behavior in response to them." The Rorschach results are especially illuminating in this connection.

Written in a style and terminology that are easy to understand, the study is very well done and represents a distinct contribution toward our understanding of the alcoholic.

LAWRENCE KOLB.

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HYPNOTISM TO-DAY. By L. M. Le Cron and J. Bordeaux. New York: Grune and Stratton, 1947. 278 p.

Because relatively little material has been published in the field of hypnotherapy, a book such as *Hypnotism To-day* is welcome for the data it supplies, permitting of a further evaluation of the hypnotic method. It is well known that the field of hypnosis has been invaded by unqualified lay persons who have emphasized the more dramatic aspects of the trance, and have imparted to the public a completely erroneous picture of hypnosis as a miraculous form of therapy. It is refreshing, therefore, to find two non-medical workers whose presentation is along scientific lines.

The book is divided into two parts: (1) *Hypnotism and Suggestion* and (2) *Hypnotherapy*. The first part contains a general historical discussion and an account of the traditional methods of inducing hypnosis. There are chapters on suggestibility, principles of suggestion, hypnotic phenomena, post-hypnotic suggestion, auto-hypnosis and auto-suggestion, theories of hypnosis, and on hypnotism and the psychic sciences. These chapters introduce a few new ideas in a well-organized and well-presented manner.

The second part of the book contains an account of the experiences of the authors in hypnotherapy, in addition to a somewhat sketchy outline of psychopathology. Conclusions are presented in summary form, the authors apparently intending the book as an introduction to hypnotherapy rather than as a textbook that details

the method by which hypnosis may be combined with the various psychotherapeutic procedures.

There are some aspects of this book to which the experienced psychotherapist will take exception; but, on the whole, it can be recommended as a serious attempt to present a broad view of the field of hypnosis.

LEWIS R. WOLBERG.

New York City.

DEEP ANALYSIS; THE CLINICAL STUDY OF AN INDIVIDUAL CASE. By Charles Berg, M.D. New York: W. W. Norton and Company, 1947. 254 p.

The author of this volume, an English analyst, has attempted to describe the substance and to catch the flavor of a full analysis for the casual and professional reader. The author selected an individual who came for treatment with no more specific symptom than that he wished to make better use of his mental equipment. Since the patient was already highly regarded both socially and intellectually, his difficulties were of the vague type not uncommonly brought to analysts and best described as problems in life fulfillment.

The writer chose this case because it shed light on the psychopathological basis of neurosis and even of normality. Analysis demonstrated the unconscious basis of much behavior in the patient that is naïvely considered to follow poor intellection or to be the result of inadequate will (*i.e.*, striving) in certain individuals. Moreover, it soon became obvious in the early hours of analysis that this man had serious sexual symptoms, definite disturbances in his interpersonal relations with men and women, and a strong sense of immaturity.

The author deals with the unconscious bases of these ego attitudes and manifestations through all the ramifications of the transference, infantile regressions, father fixation, Œdipal conflicts, and pregenital oral and anal fixations. The material as given by the patient is interlarded with the analyst's interpretations, which were offered during the daily sessions, and brief theoretical discussions pertinent to the case at hand are included. Resistances toward emotional acceptance of analytic interpretation by the patient (spectacular in the case of the transference), examples of acting out, and other evidences of behavioral reaction to analytic movement, are well reported.

The unusual dynamic feature of the case report was that the father of the patient had died at the beginning of the patient's puberty, thus allowing the latter the opportunity of fixating a fantasy homosexual relation to his father and repressing the Œdipus constellation. Aiding this was a strong disappointment with his mother which had reflections

from pregenital levels of libidinal organization. Early cannibalistic fantasies toward the mother had been repressed, with the result that only aim-inhibited instinctual drives represented in intellectual levels were unrepressed and hence recognized. The analyst clearly points out the relation between these unconscious fixations and the patient's later character development, indicated in relation to men whom he admired and women whom he disdained.

This is a history of a successful psychoanalytic treatment written in a narrative form, yet maintaining the primary purpose of instruction. The problems presented by the case seem to have been competently dealt with and the clinical points well made. At times, however, the writing is turgid and the style marred by a few poorly thought-through phrases which may be understood on the basis of the author's analytic enthusiasm. For example, in a discussion of the emotional vicissitudes experienced by well-analyzed patients, the author says, "The difference between an intellectualized 'analysis' and a real analysis is the difference between cant and life, ego and id, man and God—the difference between pretense and cure."

A similar feeling of discomfort arises in the reader from quotations from the patient's productions, from which one gets the impression that the former talks like a member of an analytic seminar rather than a patient on the couch. For example, in reconstructing his relations to his mother, the patient says: "In choosing another woman I am rendered impotent by this deeper level, the source and custodian of my potency, which wants relations with mother only. . ." And again: "And so an irksome conflict is created in my unconscious."

In justice, one must consider that the patient may have been well educated by the analyst to be able to talk near the end of analysis in terms such as: "The sort of lust for living which grown-up people around me appear to have is lacking. Maybe it is that my instincts have withdrawn their power from all courses of action and perhaps it is this withdrawal that makes it seem like a veto."

The volume contains a glossary of some twelve pages of psychiatric and psychoanalytic terms, some of which appear not to correspond with the thinking of the average psychiatrist. Such definitions as that of "schizoid" as "slightly schizophrenic" appear to be carelessly written. Nevertheless, the analysis is interesting and will repay reading by interested laymen as well as by psychiatrists and analysts, even though the latter may find themselves nonplused at the exchange of phraseology between patient and doctor.

WALTER BROMBERG.

Reno, Nevada.

THE THEATRE OF SPONTANEITY. By J. L. Moreno, M.D. New York: Beacon House, 1947. 113 p.

This slender volume is the English translation of a work produced by Dr. Moreno in Europe in 1923 *(Das Stegreiftheater)*. In the words of the preface, it marks the author's transition from religious to scientific writing, and emphasizes the measurement and charting of interpersonal relations. Its interest is partly historical and partly philosophical. Dr. Moreno discusses in an almost telegraphic style the manner in which he developed what has since been widely recognized and utilized as psychodrama, and at the same time presents the underlying concepts.

The book is so compressed that an adequate abstract or review is most difficult.

The psychiatrically oriented reader will be most interested in Parts II and III—*The Theatre of Spontaneity* and *The Therapeutic Theatre*. Dr. Moreno distinguishes the spontaneity theater's function from the Aristotelian concept of catharsis in these words (p. 97): "Catharsis takes place not only in the audience . . . and not in the dramatic personæ of an imaginary production, but primarily in the spontaneous actors in the drama who produce the personæ by liberating themselves from them at the same time."

Thus what began as a new form of art has given birth to a new and valuable form of group therapy and of group instruction—namely, Moreno's psychodrama. This book is a valuable exposition of the underlying philosophy. It should be read by all who are interested in the newer methods of studying and treating disorders of interpersonal relations.

WINFRED OVERHOLSER.

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JUNIOR SPEAKS UP. By Irving R. Abrams, M.D. New York: The Macmillan Company, 1948. 164 p.

Junior, the hero of this work, tells of his adventures in learning to live with his parents and, more important, of their learning to live with him, with the help of their pediatrician. The story is presented as a play script, Junior talking to his Shadow, the parents talking to each other, and the doctor talking to the parents.

The author frankly states in the preface that he meant to write about the problems of parent-child relationships humorously. The humor is mainly in painting caricatures of the father and mother and of the pediatrician. When one laughs, it has to be at the

people in the story, not with them. As a matter of fact, the people in this book don't really have much fun.

In the main, the child-parent relationship is depicted as a contest, with the baby trying to get the upper hand, succeeding, but then being defeated or finding the battle unnecessary through the good advice of the pediatrician. The pediatrician rather pompously gives his advice, which is usually based on concepts of child development, as if it were not really necessary to know Junior and his parents well, or to understand the dynamics of the people concerned. For the preventive purpose the author sets out to accomplish, this may actually be true, and it is probable that where more understanding is necessary, the psychiatrist, who is presented as a sort of jocose threat in the book, would have the case referred to him anyway by the good pediatrician whose name in the book is Bodybuilder.

The author has added an appendix, apparently lacking faith in the teaching technic of the early part of the book. This section, of 24 pages, is a typical baby-book presentation. It is marred by too exact standards and directions which to a large extent negate the adaptability and the insistence on individuality idealized in the earlier part of the book.

On the whole the volume is entertaining and should be informative to parents.

PAUL V. LEMKAU.

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NOTES AND COMMENTS

Meeting of the American Psychiatric Association

The One Hundred and Fourth Annual Meeting of the American Psychiatric Association was held at the Hotel Statler, Washington, D. C., May 17–20. It was attended by some 3,100 people, including members and guests.

As usual, a wide range of topics was considered in the various section meetings. Besides the more technical and clinical aspects of psychiatry, consideration was given to such subjects as "Faith and Psychopathology," with papers from Rabbi Abraham Cronbach, of Hebrew Union College, Cincinnati, and Father Noel Mailloux, of the Institute of Psychology, University of Montreal, Quebec; "Private Practice in Psychiatry," with discussion of the opportunities of such practice in small cities and rural communities; and "Group Treatment," including an account of the use of moving pictures in group psychotherapy and of a group-therapy project with parents of behavior-problem children in public schools. Psychiatric social work and psychiatric nursing also had a place on the program.

The outgoing president, Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, Washington, D. C., is succeeded by Dr. William C. Menninger, General Secretary of the Menninger Foundation, Topeka, Kansas. Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene, is president-elect. Dr. Leo Bartemeier, of Detroit, Michigan, and Dr. Howard W. Potter, of the Long Island College of Medicine, Brooklyn, N. Y., were reëlected as, respectively, secretary and treasurer of the association.

The next meeting of the association will be held in Montreal, Canada, May 22–27, 1949.

Twenty-fifth Anniversary of the American Orthopsychiatric Association

Over two thousand people attended the Twenty-fifth Anniversary Meeting of the American Orthopsychiatric Association, which was held at the Hotel Commodore, New York City, April 12, 13, and 14. Among the subjects discussed at the various sessions were "Orthopsychiatry and the Educative Process," "Orthopsychiatry and General Medicine," "Psychopathological Conditions in Childhood," "Treatment and the Institutional Setting," "The Nursery School as an Integral Part of Community Mental Hygiene," "Anthropology

and Orthopsychiatry," and "Child Analysis." There were three luncheon meetings—one on "Rehabilitation—Principles and Program"; one on the International Congress on Mental Hygiene to be held in London in August; and the third on "Psychiatric Implications of Some Educational Experiences." At the annual dinner, held on April 13, a dramatic sketch was presented by the American Theatre Wing Community Plays, the gift of Mrs. Blanche Ittelson.

The officers of the association for the coming year are: President, S. J. Beck, Ph.D., of Michael Reese Hospital, Chicago; Vice President, Edith B. Jackson, M.D., of the Department of Pediatrics, Yale University; Secretary, S. Harcourt Peppard, M.D., of the Bureau of Child Guidance, New York City; Treasurer, James S. Cunningham, M.D., of the Bureau of Mental Hygiene, State Department of Health, Hartford, Connecticut; President-elect, Marian McBee, of the New York Committee on Mental Hygiene, New York City.

The 1949 meeting of the association will be held April 4, 5, and 6 at the Hotel Stevens, Chicago.

Third Coördinating Conference of Western State Psychiatric Institute and Clinc

"The Design of Research in Mental Health" was the theme of the Third Annual Coördinating Conference of the Western State Psychiatric Institute and Clinic of Pittsburgh, Pennsylvania, which was held this year on April 1.

At the morning session, which was opened with an invocation by Reverend John C. Griffith, Assistant Pastor, Saint Paul's Cathedral, Pittsburgh, Dr. Grosvenor B. Pearson, Director of the Western State Psychiatric Institute and Clinic, spoke on "The Coördinating Conference"; Honorable Charlie R. Barber, Secretary of Welfare of the Commonwealth of Pennsylvania, on "The Department of Welfare"; Dr. Paul I. Yakolev, Director of Research and Training, Connecticut State Hospital, on "Coöperative Research: Its Strength and Weaknesses"; and Dr. Erich Lindemann, Chief of the Psychiatric Out-patient Department, Massachusetts General Hospital, and associate in psychiatry, Harvard Medical School, on "Problems in Mental Health Demanding Research."

Four meetings were held in the afternoon, devoted respectively to clinical psychiatry, nursing, psychology, and social work. Dr. Lothar B. Kalinowsky, research associate in psychiatry, Columbia University, and assistant neurologist at the Neurological Institute of New York, discussed "Research Methods in Clinical Psychiatry"; Ruth Perkins Kuehn, Dean of the School of Nursing, University of Pittsburgh, "Research Problems in Nursing"; Carney Landis,

principal research psychologist, New York State Psychiatric Institute and Hospital, "Experimental Methods in Psychopathology"; and Helen Leland Witmer, Research Director, Smith College School for Social Work, "Research in the Field of Social Work."

Reverend J. C. Greenawalt, of Western Theological Seminary, Pittsburgh, gave the invocation at the dinner meeting, which was addressed by the Governor of Pennsylvania, James Henderson Duff, and Dr. William Menninger, General Secretary of the Menninger Foundation, Topeka, Kansas. Governor Duff spoke on "Research in Mental Health from the Standpoint of the Commonwealth," and Dr. Menninger on "Research in Mental Health in the National Perspective."

Mental-Health Section of National Conference of Social Work

The National Conference of Social Work held its Seventy-fifth Annual Meeting at Atlantic City, N. J., April 17–23. The Mental Health Section was under the chairmanship of Mr. Louis de Boer, Education Secretary of the Illinois Society for Mental Hygiene.

The subjects discussed at the various sessions of the section were "Mental Health and Democracy," "Mental Hygiene for the Aged," "Current Trends in Child Guidance Clinics," "Mental Health Education," and "Mental Hygiene and Race Relations." There were also two joint sessions with the American Association of Psychiatric Social Workers—one on "The Rôle of the Volunteer in Mental Hygiene," and the other on "Community Organization for Mental Health." Dr. Samuel W. Hamilton, Superintendent of Essex County Overbrook Hospital, Cedar Grove, N. J., presided at the first, and Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene, at the second.

American Society for Research in Psychosomatic Problems

The annual meeting of the American Society for Research in Psychosomatic Medicine was held again this year in Atlantic City, N. J., at Chalfonte-Hadden Hall, May 1–2. Besides a general session, the program included a session on "Psychosomatic Problems in Pediatrics," and one on "Psychosomatic Problems in Diabetes," and a panel discussion on "Problems of Methodology in Psychosomatic Research."

To Weigh New Forces in Family Living

Detroit will be host to representatives of family-service organizations throughout the country at the 1948 biennial meeting of the

Family Service Association of America. The meeting has been scheduled for November 18 to 20 at the Book-Cadillac Hotel in Detroit, according to an announcement by Frank J. Hertel, General Director of the Family Service Association.

Under the theme, "New Forces in Family Living—New Directions in Family Service," the convention will endeavor, in general, to accent the positive developments in American family change, as well as the factors that have contributed to instability and breakdown.

Richard Brown, Executive Director of Family Service, Inc., of Providence, R. I., chairman of the program committee, states:

"Here in the United States in recent years we have been so concerned with elements that have been seemingly undermining traditional patterns of family living that we have tended to underestimate the new forces which are giving fresh meaning and promise for the family of the future. While we have been bemoaning the decline of old-fashioned parental authority, for instance, we have failed to give proper weight to the development of democracy in the home through which children share with parents new responsibilities and a right to have part in many decisions. Such changes already have influenced heavily the character of assistance provided by family service agencies and we think the time is ripe to appraise both family change and family service in positive terms."

Between 400 and 500 persons are expected at the convention in Detroit, representing a large part of the 242 agencies within the Family Service Association membership in the United States and Canada. These will include both staff and board delegates.

Two member agencies of the association in the convention city will be co-hosts to the delegates—the Family Service Society of Metropolitan Detroit and the Detroit Department of Public Welfare.

Special Lasker Award Given to Reporter

A special Lasker Award for crusading efforts in the field of mental hygiene has been given to Mike Gorman, reporter on the *Daily Oklahoman* and one of the founders of the Oklahoma Committee for Mental Hygiene. In announcing the award, Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene, cited Mr. Gorman's "intensive investigations, his positive interpretation, and the unprecedented results achieved through his clear insight into the professional viewpoint."

The award was presented at a special luncheon meeting of the Oklahoma Committee for Mental Hygiene on May 1, at the Skirvin Hotel, Oklahoma City.

Mike Gorman is a native of New York City and a graduate of New York University. He did graduate work at Columbia Univer-

sity, and New York University, where he was later on the staff. He has a master's degree in history. He became a resident of Oklahoma in 1945 after five years in the U. S. Army Air Corps.

Dr. Sutherland Receives Award for Contribution to Mental Health in Texas

Dr. Robert L. Sutherland, Director of the Hogg Foundation for Mental Hygiene, of the University of Texas, is the first recipient of the Dallas Health Museum Award for an outstanding contribution to public health in Texas. The award, consisting of an appropriate plaque, to be presented annually, was established in 1947, with the provision that it be given to an individual who had made an outstanding contribution to improve or to benefit community health in Texas, or to a group of individuals whose composite work could be regarded as the contribution of one individual.

The presentation of the award to Dr. Sutherland was made at a public meeting of the Texas State Medical Association last April. Dr. Haven Emerson, of New York City, made the presentation, which was accompanied by the following citation:

> "For his skill and activity in stimulating local responsibility in mental health education, for his profound interest in people to the end that each shall be assisted in reaching satisfactory adjustment in all relationships—this award is presented to Robert L. Sutherland, Ph.D., by the Dallas Health Museum, April 28, 1948."

Dr. Sutherland is a member of the Council of The National Committee for Mental Hygiene.

Western State Hospital, Washington, to Have Research Center

Bringing into reality plans and hopes of many years' standing, bids are expected to be called in the very near future on the research, scientific, diagnostic, and library center at Western State Hospital, Fort Steilacoom, Washington, where an intensive program of research on diseases of the nerves and brain will be instituted.

Construction of the new research center, estimated to cost between $300,000 and $400,000, will place Washington in the forefront among states that have a progressive program for the study and treatment of mental disorders, according to Jack Ballew, Director of the Department of Public Institutions.

Dr. Edward L. Turner, Dean of the Medical School of the University of Washington, expressed his interest and that of his faculty in the new center, pointing out that medical-school faculty members

had collaborated with Dr. W. N. Keller, Superintendent at Western State Hospital, on preliminary plans.

Much time remains to work out plans for joint university and hospital research, however, Dr. Turner pointed out, since the center building will probably not be ready for laboratory use for about a year.

The big mental hospital offers great opportunities for study and research on mental disease leading to new and effective treatment, Dr. Keller stated, because of the controlled situation in which patients can be observed over long periods of time. Research will not be limited to mental diseases, though major emphasis will be placed on that field.

Already ordered for the research center is a $2,500 electro-encephalograph. Dr. Keller stated that he knew of only two other machines of this kind in the Pacific Northwest. Dr. James G. Shanklin, a staff member, is now in Denver, Colorado, for a three-month course of study in the operation of the equipment.

Music as Therapy

Early returns from a nation-wide survey reveal widespread interest among physicians and research institutions in the value and use of music as a therapeutic agent. The survey is being conducted by Music Research Foundation, Inc., non-profit membership organization, and supplements the foundation's recently inaugurated series of basic research projects seeking to establish, under laboratory conditions, practical therapeutic applications for music.

The survey covers member hospitals of the American Hospital Association, American Psychiatric Association members now engaged in the private practice of psychiatry, and accredited four-year colleges, universities, and professional schools that have a music or a psychology department or both. Need for documentation of activities in this hitherto uncoördinated field is evidenced by numerous requests for information and assistance from almost every state and from many foreign countries.

The initial survey will be followed by a classification and an analysis of current research projects and applied music programs, upon completion of which a practical handbook of methodology will be prepared. Recommendations of the research committee will be included, based on findings from the foundation's basic research.

In a three-year army-authorized project, Music Research Foundation demonstrated under experimental conditions at Walter Reed General Hospital that music's therapeutic possibilities merit serious scientific investigation. Results of the announced survey will guide

the foundation in its selection of future research projects with the most promising potentialities. The organization's current research and supporting activities are under the direction of Dr. R. C. Williams, Assistant Surgeon General of the U. S. Public Health Service and chairman of the foundation's board of directors and research committee. Inquiries may be addressed to the Executive Secretary, Music Research Foundation, Inc., 1621 Connecticut Avenue, N. W., Washington 9, D. C.

New York State Broadens Occupational-therapy Program

Extension of occupational therapy to all patients whom it can benefit in the 26 hospitals and schools of the New York State Department of Mental Hygiene has been made possible by the provision of 209 new positions, according to a recent announcement by Dr. Frederick MacCurdy, Commissioner of Mental Hygiene. He added that the positions were available as of the first of June, through funds recommended by Governor Dewey in his 1948–49 budget and subsequently approved by the state legislature.

Most of the 209 new positions are established at the occupational-instructor and the occupational-aide levels. Such persons, working under the supervision of trained and experienced occupational therapists, will be of special value in conducting classes for groups of patients whose condition does not warrant their attendance at classes at the occupational-therapy centers.

Roffey Park Offers Courses in Social and Industrial Psychiatry

Roffey Park Rehabilitation Center, in England, is offering this summer a series of postgraduate courses in social and industrial psychiatry. Roffey Park provides investigation, treatment, and resettlement facilities for 120 patients of either sex suffering from industrial fatigue, maladjustment, and other manifestations of psychosomatic illness. Attached to the center is a postgraduate school, which has accommodation for 24 people of either sex, who reside during the week in which the course is offered in an attractive residential club on the fine estate, thirty-five miles from London. Psychiatrists, industrial physicians, psychologists, and social workers are invited.

The program includes lectures by distinguished workers in this field on the sociological aspect of ill health, mental health and the working environment, personnel selection, social aspects of rheumatism (by Lord Horder, Physician to the King), absenteeism in industry, and rehabilitation. Also included are films on industrial health

and rehabilitation, demonstration of cases, group discussions, and visits to neighboring institutions.

The dates are as follows: June 28–July 4; August 9–August 15; August 23–August 29; September 20–September 26. The same course will be given in each of these weekly periods: applicants should apply to the Secretary, Roffey Park, Horsham, Sussex, England, stating preferred dates. The inclusive fee, covering tuition, residence, and social activities, is $50.00.

Facts About Nervous and Mental Disorders

The following figures are quoted from a recent report of the Committee on Hospitals, of the Group for the Advancement of Psychiatry, which has announced its intention of preparing such a fact sheet annually:

Average Census of Psychiatric Patients in Hospitals in the United States:
1946 635,769
(Four out of every 1,000 persons in our population are hospitalized mental patients.)

Total Admissions to Nervous and Mental Hospitals in the United States:
1946 271,209
(Two out of every 1,000 persons in our population are admitted each year to nervous and psychiatric hospitals.)

Number of Hospital Beds in the United States:
1946—General beds other than neuropsychiatric beds 793,784
Nervous and mental beds 674,930
(41½ per cent of all hospital beds in the United States are used for nervous and mental patients.)

Occupancy of Hospital Beds in United States:
1946—General hospitals . . . . . 77.4 per cent
Nervous and mental hospitals . . . . . 94.9 per cent
(Only 51 out of every 1,000 beds for nervous and psychiatric patients are unoccupied—an unsafe figure, considering possible emergencies, repairs, painting, refurnishing, etc.)

Number of Physicians in the United States:
December 31, 1946—Total . . 206,000
Psychiatrists . . 4,000
(Less than 2 per cent of all physicians in the United States are psychiatrists.)

Ratio of Physicians to Population:
1946—Total . . . . . 1 to 680
Psychiatrists . . . . . 1 to 35,500

Number of Psychiatrists Needed in United States:
Total . . 20,000 or 16,000 additional
Ratio . . 1 to 7,100 general population
Ratio . . 10 per cent of all physicians needed for psychiatry

Ratio of Physicians to Patients in Psychiatric Institutions:
1943—Physicians and hospital superintendents (state hospitals) 3.6 to 1,000 patients
1942—Physicians and hospital superintendents (state hospitals) 3.8 to 1,000 patients
(Staff shortages were extreme.)

Ratio of Graduate Nurses to Patients in Psychiatric Institutions:
1943—7.0 graduate nurses to 1,000 patients
1942—7.5 graduate nurses to 1,000 patients
(Shortages of graduate nurses were marked.)

Standards of American Psychiatric Association:

Psychiatric hospital:
- 1 superintendent
- 1 psychiatrist per 200 resident patients, plus
- 1 psychiatrist per 100 annual admissions
- 1 social worker per 100 annual admissions

Mental-hygiene clinic:
(For non-hospitalized cases in a general population of 100,000)
- 1 psychiatrist
- 1 psychologist
- 2–3 psychiatric social workers

Importance of Follow-Up Care (after Hospital Care):

1945—23 per cent of admissions were readmissions

Annual Cost of Hospitalized Nervous and Mental Patients in the United States:

Total cost:

State hospital, 1945	$165,743,122
State hospital, 1943	138,491,553
V. A. hospital, 1946	55,087,173
V. A. hospital, 1943	29,382,762

Per patient cost per year:

State hospital, 1945	$ 386.80
State hospital, 1943	335.84
V. A. hospital, 1946	1,288.45
V. A. hospital, 1943	841.12

(Costs are increasing each year.)

Cost to Keep a Patient in an Institution (Estimated):

State hospital—	
15 year period	$ 8,100
Veterans hospital—	
15 year period	15,000

Per Patient Expenditure for Maintenance, State Hospitals for Mental Disease, 1945:

Total U. S. (182 hospitals reported)	$386.80
Selected states:	
District of Columbia	714.67
Wisconsin	563.11
New York	512.34
Illinois	499.11
New Hampshire	479.60
Michigan	468.89

(Eight states reported less than $250 per patient cost.)

Total Annual Cost for Hospital and Institutional Care — Mental Disease, Mental Defectives and Epileptics:

1945	$300,000,000
1943	192,243,000

Residency Training in Psychiatry:

All hospitals with psychiatric residencies	159
General hospitals with psychiatric residencies	48
Total residencies in psychiatry	903

Comparative Statistics—Major Diseases:

Disease	Total number of patients, 1946	Deaths per year, 1945	Death rate *	Money for research
Cancer	500,000 to 600,000	177,464	134.00	(not available)
Tuberculosis	117,910	52,916	41.30	(not available)
Poliomyelitis	25,191	1,186	0.85	$6,500,000
Nervous and mental diseases	800,000 to 900,000	50,000†	60.00†	$3,000,000

* Per 100,000.
† Estimated. (1943 deaths totaled 51,218.)

A Fellowship in Industrial Psychiatry

A two-year training fellowship, available to men or women who have had two or three years of psychiatry, is being offered at the New York State School of Industrial and Labor Relations, Cornell University. The fellow will receive training in such core subjects as labor economics, labor law, collective bargaining, and human relations in industry. The latter field would bring to his attention the extensive work that has been done by social psychologists and cultural anthropologists in social and psychological strains in industrial settings.

On the basis of his previous psychiatric training, the fellow would be expected to participate in the teaching of human relations, particularly in matters relevant to human motivation. Aside from academic studies, he would devote at least half-time to active work in human-relations problems in a plant, a labor union, or in government offices. This will provide him with actual experience and contacts useful in securing and filling positions in industrial psychiatry.

The formal title of the fellowship is "The Fellowship in Industrial Psychiatry in the New York State School of Industrial and Labor Relations." The stipend is being provided from a fund made available by the Carnegie Corporation of New York. The amount of the fellowship is flexible up to the sum of $5,000 per year. The school expects to make a grant in terms of the previous experience of each particular fellow.

For further information with regard to the fellowship, write to Dr. Alexander H. Leighton, Professor of Industrial Psychiatry, New York State School of Industrial and Labor Relations, Cornell University, Ithaca, New York.

News of Mental-hygiene Societies

Alabama

The Alabama Society for Mental Health has been adopted as the official name for the Alabama group formerly known as the Alabama Society for Mental Hygiene. The executive board recommended this change at the annual meeting on March 26. The work of the society has been greatly expanded during the past year. Exploratory meetings have been held both in Mobile and in Montgomery to encourage the organization of local chapters to be affiliated with the state group. A constitutional change was accepted at the annual meeting, providing for a board of directors of fifteen members to serve overlapping terms of three years. This board will provide continuity in society policy and management.

A long-range program has been described in a recent publication of the society, *A Mental Health Program for Alabama.* The booklet is being widely distributed throughout the state in an effort to enlarge public support for the work of the society. Solicitation of funds is now being made to make possible the employment of an executive secretary.

Connecticut

The Connecticut Society for Mental Hygiene held its Fortieth Annual Meeting at the New Haven Lawn Club, on Thursday, June 3, 1948. Dr. Daniel Blain, Medical Director of the American Psychiatric Association, spoke on "Social and Psychological Attitudes of Mental Health."

The society has published Dr. Lawrence S. Kubie's paper on "The Future of Preventive Psychiatry," and a limited number of copies are available, at 10¢ each, at the society's offices, 152 Temple Street, New Haven 10, Connecticut.

Hawaii

The most interesting news from the Territory of Hawaii, according to a report received from Mrs. A. W. Hackfield, Executive Secretary of the Mental Hygiene Society of the Territory, is the growth of the bureau of mental hygiene and the child-guidance clinic. Both of these departments are under the territorial board of health. At present, there are three psychiatrists on the staff—the director, Dr. John G. Lynn, Dr. Dorothy S. Natsui, and Dr. Yan Tin Wong. There are also six psychiatric social workers—three on the outside islands and three in Honolulu. This whole division has developed since Dr. Lynn's arrival in November, 1947.

Also of interest, from the point of view of the society, are the resolutions adopted by the Territorial Conference of Social Welfare at their annual meeting in May, recommending full support of the mental-hygiene society and increased appropriations for the work of existing psychiatric facilities and for the extension of such services to other parts of the islands.

In its educational program, the society has found that the two most popular phases of its work have been the records, *Meet Your Mind,* and the many new movies in the mental-health field. Both of these media have been used as bases for discussion, and they have proved stimulating to the groups in which they have been used. Since the radio program, *Doorway to Life,* is not heard in the islands, the mental-hygiene society and the Child and Family Service are paying for the transcriptions and broadcasting of this program.

In March, the mental-hygiene society and the Graduate School of the School of Social Work, University of Hawaii, jointly sponsored an open meeting at which Dr. David Levy, of New York City, who was visiting the islands, spoke on "Approaches Toward Understanding Behavior Disorders." The meeting was held in the auditorium at the University of Hawaii, which was packed to overflowing.

One of the members of the mental-hygiene society, J. Ballard Atherton, has recently been appointed to serve on the Council of The National Committee for Mental Hygiene.

Illinois

Upon the stimulus of the Illinois Society for Mental Hygiene, representatives of the society and of the Illinois Psychiatric Society met with Dr. Cross, director of the state department of public health, which had been declared the authority in Illinois for the distribution of National Mental Health Act funds, and Dr. Cross accepted the suggestion of this group that an advisory committee be available for consultation in the operation of the program. Dr. Cross appointed a committee, consisting of representatives from the Illinois Society for Mental Hygiene, the Illinois Psychiatric Society, the Illinois State Medical Society, and the Illinois Department of Public Welfare.

This committee has been actively at work and has been used by the department of public health in the determination of allocations to agencies as well as in the determination of policy. The department has accepted the recommendation of the committee that National Mental Health Act funds be used primarily for educational purposes rather than for the development of direct services.

Of the $150,000 allocated to the state of Illinois, approximately $50,000 has been given to the city of Chicago for the creation of a division of mental hygiene in the city board of health. The president of the board of health has appointed an advisory committee with representatives from the various medical schools and the Illinois Society for Mental Hygiene. Pending the appointment of a director of this division, the medical director of the society has been appointed as acting director. A psychiatric social worker has already been employed.

For the biennium ending June 30, 1948, a large share of the funds allocated to the city will be used to subsidize clinics to enable them to enlarge their treatment services. For the biennium beginning July 1, 1948, money will be used primarily for educational purposes rather than for subsidizing clinics or for direct treatment services.

A recent press notice quoted Mr. Cassius Poust, Director of the Illinois Department of Public Welfare, as saying that the depart-

ment is prepared to launch a system of community clinics with the objective of a preventive-treatment program.

The department, according to this article, is convinced that the building of new hospitals is not the answer to the constantly growing state-hospital population. The need for new construction for replacement purposes as well as for some additional bed space is recognized, but this can never cope with the 1,000 additional patients found in mental hospitals each year.

In view of this the department is convinced that some effort has to be made to prevent the hospitalization of patients and, therefore, plans greatly to expand its community-clinic program.

The Illinois Society for Mental Hygiene is particularly pleased to note this development in the department of public welfare, in view of the fact that the society has been pressing for this development for several years. It was also the major emphasis in the mental-hospital project carried on by the society in 1947.

Iowa

The Iowa Society for Mental Hygiene held its annual meeting on April 21, 1948, at Des Moines, Iowa. The principal speaker was Dr. James Maddux, of the United States Public Health Service, who spoke on The National Mental Health Act, particularly as it relates to Iowa.

Mrs. G. M. Brown, Mental Health Chairman of the American Legion Auxiliary, reported that nine district mental-health conferences had been held in institutions in Iowa, including state hospitals, schools for the feebleminded, and training schools. Three hundred and fifty-one members joined the mental-hygiene society.

The following officers were elected: President, Mr. King Palmer; Vice President, Dr. Wilbur Miller; Second Vice President, Dr. C. C. Graves; Treasurer, Mrs. Ray Mills; Secretary, Mrs. M. Opal Fore; and Executive Director, Dr. Norman D. Render.

Massachusetts

On July 21 and 22, the Massachusetts Society for Mental Hygiene and the Harvard University Summer School are co-sponsoring a conference on mental health. The presiding officer throughout the conference will be Dr. Karl A. Menninger. Speakers will be Dr. Harry C. Solomon, Dr. Robert H. Felix, Dr. Lawrence S. Kubie, Dr. Ernest W. Burgess, Dr. Clyde Kluckhohn, and Dr. Carl R. Rogers.

The Massachusetts Society for Mental Hygiene and the Massachusetts Central Health Council, which is made up of representatives of all state-wide health agencies and of local health councils,

have appointed a joint committee to assist local communities develop plans for mental-health services to meet their respective needs.

Eleven preparatory commissions were organized in Massachusetts last winter to carry on multi-discipline discussions on topics related to "Mental Health and World Citizenship," the central theme of the International Congress on Mental Health to be held in London in August, 1948. In addition to the reports formulated by these eleven groups, three other papers that have direct bearing on this broad topic, but that were not prepared at the instigation of the congress committee, have been forwarded to London.

Michigan

The week of April 5–11, 1948, was celebrated as Mental Health Week in Michigan, in accordance with a proclamation issued on March 16 by Governor Kim Sigler.

The Michigan Society for Mental Hygiene, which had been largely instrumental in the issuance of the proclamation, reports splendid coöperation from the Michigan Junior Chamber of Commerce, the Michigan Council of Churches, the Michigan Department of Mental Health, libraries, the psychiatric profession, and the public press, in carrying on the activities of this week. Fourteen radio stations were carrying the series, *For These We Speak*, as a result of the society's promotion of activities at this time; and these same stations are anxious to carry the next series, *The Tenth Man*, starting in the fall.

Nevada

The Nevada State Mental Hygiene Society started its second year of activity in April of this year. Membership is still relatively small, but the meetings are enthusiastic and often vigorous.

The society has actively promoted some changes in the state mental hospital (for one thing, removal of a cemetery from the grounds), has made an effort to stimulate the development of a mental-hygiene clinic or an information center, and has attempted to interest the state-health authority in utilizing federal funds available under the National Mental Health Act.

Oregon

The annual meeting of the Oregon Mental Hygiene Society was held on May 24, as the final event in the annual Better Mental Health Week, endorsed by the governor. During the week, the society had a feature story in one of the Portland papers, items in papers throughout the state, mental-hygiene exhibits in 21 of the 36 counties, and several radio broadcasts.

At the May meeting of the board of the society, a revised con-

stitution was adopted and the name of the society was changed to "Mental Health Association of Oregon."

Pennsylvania

Two state mental hospitals in Pennsylvania are sponsoring summer service units this summer in coöperation with nearby colleges. The Public Charities Association of Pennsylvania helped to initiate arrangements between Wernersville State Hospital and Albright College. Another unit has been arranged independently by Norristown State Hospital in coöperation with Bryn Mawr, Haverford, and Swarthmore Colleges. Members of these units will work as regular attendants for from ten to thirteen weeks and will be given formal instruction by the hospital.

Texas

At its Fifteenth Annual Conference in March, Dr. Talma W. Buford, of Pattonville, was chosen by the Texas Society for Mental Hygiene to receive the first annual Hogg Foundation Award of $250.00 for distinguished service in the cause of mental health in the state of Texas.

The award was presented with the following statement:

"The committee on awards found it difficult to choose one person from the number of individuals who have helped to advance the program of mental hygiene in this state. Among the pioneers who have given generously of their time, talents, and finances to this work, in which we all are interested, is a man who has served as a country doctor for nearly half a century. At his own expense, as early as 1924, he personally held mental-health conferences in north Texas. On such occasions he entertained as many as two hundred guests at a barbecue and then had eminent mental hygienists to address the group.

"At his own expense he visited both state and federal prisons and mental hospitals in many sections of the United States. He has long served on legislative committees of the Texas Medical Association. He spent one year in psychiatric study in Colorado; and another, at Columbia University.

"He is one of a small group of persons responsible for the organization of the Texas Society for Mental Hygiene. For years he served as vice president and chairman of the legislative committee of the society and was a valued member of its board of directors.

"He is known throughout the State for his unfailing and intelligent interest in mental health. Best of all, he has given to the rural areas of north Texas services that metropolitan areas have not been able to purchase with money alone.

"He is a modest man with warm affection for man, woman, and child. His long life has been one of service in which his wife, Georgia, has played no small part.

"It is with pleasure that Dr. Talma W. Buford, of Pattonville, Texas, is named as the society's distinguished member for 1948."

At this same meeting, plans were laid for a survey of the mental-health resources in Texas; and legislative action looking toward improvement in the commitment laws of Texas was designated as of first priority in the year's activities.

Dr. Ozro T. Woods, surgeon, of the Dallas Medical and Surgical Clinic, was reëlected president of the society.

Utah

The Utah Society for Mental Hygiene reports that a mental-health institute was held during the week of June 21–25, under the sponsorship of the Utah State Welfare Commission, the Utah State Hospital, and the University of Utah, with the coöperation of Brigham Young University, Utah State Agricultural College, and Weber College. Dr. Owen P. Heninger, Superintendent of the Utah State Hospital and a member of the executive committee of the Utah society, is in charge of mental-health activities under the state welfare commission, and as such was very active in arranging the institute.

The society reports further that Utah is organizing a mental-hygiene clinic under the National Mental Health Act. Dr. H. A. N. Bruckshaw has been appointed psychiatrist, and a staff is being organized. It is hoped that the clinic will be functioning within a very short time.

Washington

The Washington Society for Mental Hygiene celebrated its Twenty-first Anniversary at the annual dinner meeting, May 7, with "Coming of Age" as the theme. The annual-meeting program emphasized that the growth of the society over a period of twenty-one years, in terms of educational programs, legislative accomplishments, institutional reforms, and state-wide community organization, has been toward better social relations based on individual maturity.

Two institute sessions were included in the annual-meeting program. One session was led by Ralph M. Stolzheise, M.D. on the subject, "Are Our State Institutions Serving the Needs of Our People?" The discussion was based on a report presented by the society's committee on institutions, which has been making personal contacts with the several state institutions. The other session, led by Miss Lillian Hocking, was on the subject "Emotional Adjustment to the Job." Persons invited to this session include representatives of management and labor, vocational counselors, and personnel workers. More extensive work in the field of industrial relations is planned by the society as a follow-up to this institute.

Wisconsin

Wisconsin, like many other states, has not made appropriations in the past in sufficient amounts to enable the hospitals to be staffed and equipped to give the type of service that medical and psychological science can now provide. The old hopelessness about recovery, current when the two state hospitals were established for "stationary cases," still persists, even in urban areas. In some sections of the state hospitalization is always postponed until patients finally arrive at the state hospitals too sick and too fixed in their disordered thinking to yield satisfactorily to treatment.

The Wisconsin Society for Mental Health is now literally taking state-hospital personnel, with their story of hope in early treatment, to the people of the state. Wisconsin is divided into two hospital districts, each served by one of the two state hospitals. Panel discussions entitled, "Civic Responsibility for Mental Health," are being scheduled under local auspices in five strategically located centers in each hospital district.

The panel is composed of the hospital superintendent, a member of his staff, a school psychologist, and the executive director of the Wisconsin society. The school psychologist presents the parent-school responsibilities for training of the child for wholesome living. The preventive aspects of a school mental-health program that provides counsel with parents and supplements family training is emphasized. The executive director presents nine specific duties that can be accepted as the responsibility of citizens for mental health in home, community, and state. The staff member presents the responsibility of the general medical practitioner for recognizing and treating patients who do not require hospital care. The superintendent discusses the nature of the hospital care that should be provided for those whose illness "requires a changed environment for recovery."

One panel was presented May 14, before an audience of between 400 and 500 people. The "try-out" was sponsored by the county medical auxiliary, and credit should be given to this group for their courage and initiative. The second panel was held June 16, in the northern part of the state, under the joint chairmanship of the president of the county medical association and the minister of a local church. Guests from surrounding counties were included in the invitations. The talks include many practical observations which bring out questions from the floor immediately after the formal presentation. The same type of panel will also be presented before the annual meeting of several state-wide groups during the fall.

All this is in preparation for the convening of the state legisla-

ture next January, when a radical change in the size of appropriations for mental-health services must be made. The Wisconsin society is also firmly convinced that teaching people the qualities of an efficient hospital is one way of insuring sustained, intelligent interest in state hospitals for years to come.

Recent Publications

The *Directory of Psychiatric Clinics in the United States,* mentioned in the April issue of Mental Hygiene, is now available for distribution. Copies may be obtained at a price of $1.00 each, with four cents additional for postage, from The National Committee for Mental Hygiene, 1790 Broadway, New York 19, N. Y.

The National Foundation for Infantile Paralysis has issued in booklet form the proceedings of its conference in Atlantic City, New Jersey, last February, on "Advancing the Education of the Hospitalized Child." The emphasis, as stated by Sally Lucas Jean, the foundation's consultant in health education, "is upon the importance of having all those who serve the child share in planning his educational program. In this way, it can be individualized to fit his needs. Of equal value is the stress on group activity to develop the child's personality and aid in his psychological adjustment."

Copies of the proceedings are available without cost at the offices of the National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y.

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STATE MENTAL-HYGIENE ORGANIZATIONS

Alabama Society for Mental Hygiene. Mrs. R. I. Schwartz, 17 Winthrop Ave., Birmingham 9, Ala.

Arizona Society for Mental Hygiene. Rev. A. K. Krohn, President, 318 West Granada, Phoenix, Ariz.

Northern California Society for Mental Hygiene. G. Eleanor Kimble, Ph.D., Executive Secretary, 1095 Market Street, San Francisco 3, Calif.

Southern California Society for Mental Hygiene. Mrs. Helene M. Lipscomb, Executive Director, 600 South Hobart Blvd., Los Angeles 5, Calif.

Connecticut Society for Mental Hygiene. Miss Frances Hartshorne, Executive Secretary, 152 Temple St., New Haven 10, Conn.

Delaware Society for Mental Hygiene. H. Edmund Bullis, Executive Director, 1308 Delaware Ave., Wilmington 19, Del.

Florida: Mental Health Society of Southeastern Florida. Chester M. Wright, President, 700 S. W. 12th Ave., Miami 36, Fla.

Georgia Society for Mental Hygiene. J. S. Scarborough, Jr., c/o Armstrong Junior College, Savannah, Ga.

Idaho and Eastern Washington: Interstate Mental Hygiene Association. L. J. Elias, President, c/o Department of Rural Sociology, Washington State College, Pullman, Wash.

Illinois Society for Mental Hygiene. Dr. Rudolph G. Novick, Medical Director, 343 South Dearborn St., Chicago 4, Ill.

Indiana Council for Mental Health. Dr. E. Burdette Backus, President, 415 East 48th St., Indianapolis, Ind.

Iowa State Society for Mental Hygiene. Dr. Norman D. Render, Executive director, c/o State Hospital, Clarinda, Iowa.

Kansas Mental Hygiene Society. Dr. Lewis L. Robbins, c/o Menninger Clinic, Topeka, Kans.

Kentucky Mental Hygiene Association. Mrs. Ella Layne Brown, Executive Secretary, 220 Capitol Ave., Frankfort, Ky.

Louisiana Society for Mental Health. Loyd Rowland, Executive Secretary, 816 Hibernia Bank Building, New Orleans 12, La.

Maine Teachers Mental Hygiene Association. University of Maine, Orono, Me.

Maryland Mental Hygiene Society. Dr. Ralph P. Truitt, Executive Secretary, 601 West Lombard St., Baltimore 1, Md.

Massachusetts Society for Mental Hygiene. William H. Savin, Executive Director, 3 Joy Street, Boston 8, Mass.

Michigan Society for Mental Hygiene. Harold G. Webster, Executive Secretary, 153 E. Elizabeth St., Room 645, Detroit 1, Mich.

Minnesota Mental Hygiene Society. Dr. Alexander G. Dumas, Medical Director, 3933 Bryant Ave. South, Minneapolis, Minn.

Missouri Association for Mental Hygiene. Mrs. Elizabeth Lingenfelter, Secretary, 1020 McGee St., Kansas City 6, Mo.

Nevada State Mental Hygiene Society. Dr. Walter Bromberg, 140 North Virginia St., Reno, Nev.

New York State Committee on Mental Hygiene of the State Charities Aid Association. Miss Marian McBee, Executive Secretary, 105 East 22nd St., New York 10, N. Y.

North Carolina Mental Hygiene Society. Harry K. Dorsett, Secretary, Meredith College, Raleigh, N. C.

Ohio Mental Hygiene Association. Mrs. Marion S. Wells, Acting Executive Secretary, 1014–15 Huntington Bank Bldg., Columbus 15, Ohio.

Oklahoma Committee for Mental Hygiene. W. James Logan, Acting Executive Secretary, 620 N. W. 21st Street, Oklahoma City 3, Okla.

Oregon: Mental Health Association of Oregon. Miss June J. Joslyn, Executive Secretary, 229 Park Bldg., Portland 5, Ore.

Pennsylvania: Mental Hygiene Division, Public Charities Association of Pennsylvania. Ross W. Sanderson, Jr., Secretary, 311 South Juniper St., Philadelphia, Pa.

Rhode Island Society for Mental Hygiene. Dr. Gertrude Muller, Medical Director, 100 North Main St., Providence, R. I.

South Carolina Society for Mental Hygiene. Miss Norma E. Hallett, President, Clinton, S. C.

Texas Society for Mental Hygiene. Mrs. Elizabeth F. Gardner, Executive Secretary, 1617 Watchhill Road, Austin 21, Tex.

Utah Society for Mental Hygiene. Charles L. McKell, Executive Secretary, Box 270, Provo, Utah.

Vermont Society for Mental Hygiene. Miss Lois Stearns, Secretary, c/o Addison County Health Center, Middlebury, Vt.

Virginia Mental Hygiene Society. Mr. F. W. Gwaltney, Executive Secretary, 309 North 12th St., Richmond 19, Va.

Washington Society for Mental Hygiene. George F. Ault, Executive Secretary, 408 Seaboard Bldg., Seattle 1, Wash.

Wisconsin Society for Mental Health. Dr. Esther H. DeWeerdt, Executive Secretary, 405 East Grand Ave., Beloit, Wisc.

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